

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 0486

4891

|  |  |   |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b> |  | c. LENGTH OF STAY IN 1b<br><b>25 Days</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>36 Capital Hgts</b>  |  | d. STREET ADDRESS<br><b>6137 Shadyside</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First<br><b>George</b><br>Middle<br><b>Albert</b><br>Last<br><b>Adams</b>  |  | 4. DATE OF DEATH<br>Month<br><b>April</b><br>Day<br><b>19</b><br>Year<br><b>1958</b>                |  | 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/29/76</b>  |  | 9. AGE (In years lost birthday)<br><b>81</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Building Inspector</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>State Maryland</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Kentucky</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>Alonzo Adams</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Kathryn Severhouse</b>                                  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>                |  |
| 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Lena B Adams (Wife)</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>434.1 Congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Uremia</b><br>DUE TO<br>(c) <b>mercurial toxicity</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b><br><b>4 weeks</b><br><b>5 weeks</b>   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                           |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)        |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <b>4/11</b> , 19 <b>58</b> , to <b>4/19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/19</b> , 19 <b>58</b> , and that death occurred at <b>7:50P.M.</b> from the causes and on the date stated above. |  | ADDRESS (Street, city or town, state)<br><b>3408 Chode / S / And Mt Rainier Md 4101 st</b>          |  | DATE SIGNED<br><b>4/19/58</b>   |  | ACTUAL SIGNATURE<br><b>Leon R. Levitsky</b>   |  | PHYSICIAN'S NAME (Type)<br><b>Dr. Leon R. Levitsky</b>  |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                             |  | 22b. DATE THEREOF<br><b>4/23/58</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland Md.</b>                                |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.W. Chambers Co. 517 11th St. S.E. Wash. D.C.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 23 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. W. Chambers</b>   |  | 24c. REGISTRAR'S SIGNATURE   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

**RECEIVED**  
**BUREAU V. E.**  
 APR 23 1958

|                                      |  |                                     |  |                                       |  |                                     |  |
|--------------------------------------|--|-------------------------------------|--|---------------------------------------|--|-------------------------------------|--|
| NAME OF DECEASED<br>[Illegible]      |  | SEX<br>[Illegible]                  |  | AGE<br>[Illegible]                    |  | DATE OF BIRTH<br>[Illegible]        |  |
| PLACE OF BIRTH<br>[Illegible]        |  | CITY<br>[Illegible]                 |  | STATE<br>[Illegible]                  |  | COUNTRY<br>[Illegible]              |  |
| OCCUPATION<br>[Illegible]            |  | EDUCATION<br>[Illegible]            |  | MARRIAGE<br>[Illegible]               |  | RELIGION<br>[Illegible]             |  |
| CAUSE OF DEATH<br>[Illegible]        |  | MANNER OF DEATH<br>[Illegible]      |  | DATE OF DEATH<br>[Illegible]          |  | PLACE OF DEATH<br>[Illegible]       |  |
| SIGNATURE OF DECEASED<br>[Illegible] |  | SIGNATURE OF WITNESS<br>[Illegible] |  | SIGNATURE OF PHYSICIAN<br>[Illegible] |  | SIGNATURE OF CORONER<br>[Illegible] |  |
| DATE OF SIGNATURE<br>[Illegible]     |  | DATE OF SIGNATURE<br>[Illegible]    |  | DATE OF SIGNATURE<br>[Illegible]      |  | DATE OF SIGNATURE<br>[Illegible]    |  |

## 4933 CERTIFICATE OF DEATH

04870

Reg. Dist. No.

|   |                               |  |                                   |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>         |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>   |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                               | d. STREET ADDRESS <u>2805- Britton Drive</u>   |                                   |
| 3. NAME OF DECEASED (Type or print) <u>ANNA MARIE BARKLEY</u> First Middle Last   |                               | 4. DATE OF DEATH <u>APRIL 30</u> Month Day Year <u>1958</u>  |                                   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-10-1875</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs.  |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u>  |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>Pa</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |                                   |
| 13. FATHER'S NAME <u>Michael Alley</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Mary Wallace</u>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                               | 16. SOCIAL SECURITY NO. <u>M. Samuel Barkley Stone</u>   |                                   |
| 17. INFORMANT <u>Stone</u>  |                               | Address <u>2</u>   |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u><br>DUE TO <u>Myocardial insufficiency</u><br>(b) <u>Hypertensive Arteriosclerotic Heart</u><br>DUE TO <u>Age 83 years</u><br>(c) <u>Stroke</u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>6 months</u><br><u>8 years</u>   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Age 83 years</u>  |                               |  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that I attended the deceased from <u>June</u> 19 <u>49</u> to <u>April 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 29</u> , 19 <u>58</u> , and that death occurred at <u>8:05 PM</u> , from the causes and on the date stated above.                                   |                               |  |                                   |
| ACTUAL SIGNATURE <u>Sidney W. Lowry</u> M.D.  |                               | ADDRESS (Street, city or town, state) <u>7200- MARLBORO PIKE SEY</u>   |                                   |
| PHYSICIAN'S NAME (Type) <u>SIDNEY W. LOWRY M.D.</u>   |                               | DATE SIGNED <u>11/31/58</u>  |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>5-2-1958</u>  |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Switzland Md</u>  |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Mattingly</u>  |                               | ADDRESS <u>Wash D.C</u>  |                                   |
| 24a. REC'D BY REGISTRAR <u>Wash D.C</u>   |                               | 24b. REGISTRAR'S SIGNATURE <u>DeDeauch</u>   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 4890 CERTIFICATE OF DEATH

Reg. Dist. No. 04871

|  |                                  |   |                                     |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>            |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mount Rainier</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>13 years</b>  |                                     |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>16 Mount Rainier</b>  |                                  |   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>4017 - 33rd. street</b>   |                                  | d. STREET ADDRESS<br><b>4017 - 33rd. street</b>   |                                     |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Sarah</b> Middle <b>Ann</b> Last <b>Barney</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>1</b> Year <b>1958</b>  |                                     |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>9/3/1873</b> |
| 9. AGE (In years last birthday)<br><b>84 yrs.</b>  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>in own home</b>   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Independence, N.Y.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |
| 13. FATHER'S NAME<br><del>Edmond Potter</del> <b>Edmond Potter</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Antoinette Enos</b>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                     |
| 17. INFORMANT<br><b>Miss Floy E. Barney</b>  |                                  | Address<br><b>4017 - 33rd. street</b>   |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Refractor</b><br>442X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-vascular-Pericardial Disease</b><br>DUE TO<br>(c) <b>Arteriosclerosis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>2600 Diabetes Mellitus</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I attended the deceased from <b>Dec. 1957</b> , to <b>4/1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/31</b> , 19 <b>58</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above.   |                                  |   |                                     |
| ACTUAL SIGNATURE<br><b>R.S. Williams</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>35 New York Ave NW WASH. DC</b>   |                                     |
| DATE SIGNED<br><b>4/1/58</b>   |                                  |   |                                     |
| PHYSICIAN'S NAME (Type)<br><b>R.S. WILLIAMS</b>  |                                  | <b>35 NEW YORK AVE NW WASH. DC</b>  |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4/4/1958</b>  |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>   |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Nalley's Funeral Home Inc. Mt. Rainier, Md.</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>APR 7 '58</b>   |                                     |
| 24b. REGISTRAR'S SIGNATURE<br><b>Deer</b>  |                                  |   |                                     |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 7 1953

RECEIVED

## 4892 CERTIFICATE OF DEATH

Reg. Dist. No. 04872

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGE MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY                              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>   |  | c. LENGTH OF STAY IN <b>adm 5-4-1954</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> 3001-4        |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | d. STREET ADDRESS <b>3218 FAIR AVE.</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>SUSAN A. BASSETT</b>  |  | 4. DATE OF DEATH <b>4 24 1958</b>  |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>6-14-1871</b>                              |
| 9. AGE (In years lost birthday) <b>86</b> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>not any</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |  |
| 13. FATHER'S NAME <b>Leonard BAREFORD</b>  |  | 14. MOTHER'S MAIDEN NAME <b>ROSA SAUNDERS</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <b>HOSPITAL RECORDS LAUREL SANITARIUM</b>  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>CORONARY THROMBOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO<br>(c) <b>many years</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>several hrs</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis with psychotic reaction</b>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. 1. p. m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                           |
| 21. I certify that I attended the deceased from <b>June 9, 1956</b> , to <b>April 24, 1958</b> , that I last saw the deceased alive on <b>4-24-58</b> , and that death occurred at <b>11:05 P.M.</b> , from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <b>Erika P. Kraemer</b>   |  | ADDRESS (Street, city or town, state) <b>LAUREL Sanitarium</b> DATE SIGNED <b>4-24-58</b>  |  |
| PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>  |  | <b>LAUREL Maryland</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 22b. DATE THEREOF <b>4-28-58</b>   | 22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>   | 22d. LOCATION (City, town, or county) (State) <b>Baltimore</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>   |  | ADDRESS  |  |
| 24a. REC'D BY REGISTRAR <b>APR 29 1958</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>W. Cook</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                      |  |                       |  |                         |  |
|----------------------|--|-----------------------|--|-------------------------|--|
| DATE OF DEATH        |  | PLACE OF DEATH        |  | MANNER OF DEATH         |  |
| APR 29 1958          |  | BALTIMORE, MARYLAND   |  | NATURAL                 |  |
| TIME OF DEATH        |  | AGE                   |  | SEX                     |  |
| 10:15 PM             |  | 65                    |  | M                       |  |
| RACE                 |  | EDUCATION             |  | OCCUPATION              |  |
| WHITE                |  | HIGH SCHOOL           |  | RETIRED                 |  |
| RELIGION             |  | MARITAL STATUS        |  | PREVIOUS ILLNESS        |  |
| METHODIST            |  | MARRIED               |  | NONE                    |  |
| CAUSE OF DEATH       |  | IMMEDIATE CAUSE       |  | UNDERLYING CAUSE        |  |
| HEART DISEASE        |  | CORONARY THROMBOSIS   |  | CORONARY ARTERY DISEASE |  |
| SIGNED BY            |  | WITNESSED BY          |  | CERTIFIED BY            |  |
| J. H. SMITH, M.D.    |  | J. H. SMITH, M.D.     |  | J. H. SMITH, M.D.       |  |
| LOCAL HEALTH OFFICER |  | COUNTY HEALTH OFFICER |  | STATE HEALTH OFFICER    |  |
| J. H. SMITH, M.D.    |  | J. H. SMITH, M.D.     |  | J. H. SMITH, M.D.       |  |

BUREAU X. E.

APR 29 1958

RECEIVED

4876 CERTIFICATE OF DEATH

04873

Reg. Dist. No.

|  |                                     |  |  |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>W. Hyattsville</b>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>W. Hyattsville</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>3407 Nicholson St.</b>  |                                     | d. STREET ADDRESS<br><b>3407 Nicholson St.</b>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elizabeth</b> Middle <b>Hamilton</b> Last <b>Beach</b>   |                                     | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>21</b> , Year <b>1958</b>  |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/25/80</b>   |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.  |                                     | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>             |
| 12. CITIZEN OF WHAT COUNTRY?   |                                     |  |  |
| 13. FATHER'S NAME<br><b>Stephen Hamilton</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Lammon</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                     | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Stephen Beach</b>  |                                     | <b>9317 Worrell Ave. Lanham, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                     |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 weeks</b><br><b>years</b>         |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     |
| 20f. (City or town) (County) (State)   |                                     |  |  |
| 21. I certify that I attended the deceased from <b>July</b> 19 <b>57</b> , to <b>April 21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>April 19</b> , 19 <b>58</b> , and that death occurred at <b>5</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>5432 QUEENS CHAPEL RD</b> DATE SIGNED <b>4/21/58</b>  |                                     |  |  |
| ACTUAL SIGNATURE <b>Ronald S. Fleischer</b> M.D.   |                                     |  |  |
| PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>   |                                     | <b>HYATTSTVILLE, Md</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   | 22b. DATE THEREOF<br><b>4/25/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Prince George, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co.</b>  |                                     | 24a. REC'D BY REGISTRAR<br><b>DATE APR 24 '58</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Overman</b>                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                        |  |                        |  |                       |  |                        |  |
|------------------------|--|------------------------|--|-----------------------|--|------------------------|--|
| NAME OF DECEASED       |  | SEX                    |  | AGE                   |  | DATE OF BIRTH          |  |
| JAMES H. HARRIS        |  | MALE                   |  | 45                    |  | JAN 15 1890            |  |
| RESIDENCE              |  | OCCUPATION             |  | CAUSE OF DEATH        |  | MANNER OF DEATH        |  |
| 1234 E. BALTIMORE ST.  |  | LABORER                |  | HEART DISEASE         |  | NATURAL                |  |
| DATE OF DEATH          |  | PLACE OF DEATH         |  | CERTIFICATE OF DEATH  |  | MANNER OF DEATH        |  |
| APR 10 1933            |  | BALTIMORE, MD.         |  | JAMES H. HARRIS       |  | NATURAL                |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF DECEASED |  | SIGNATURE OF WITNESSES |  |
| J. H. HARRIS           |  | J. H. HARRIS           |  | J. H. HARRIS          |  | J. H. HARRIS           |  |
| DATE OF DEATH          |  | PLACE OF DEATH         |  | CERTIFICATE OF DEATH  |  | MANNER OF DEATH        |  |
| APR 10 1933            |  | BALTIMORE, MD.         |  | JAMES H. HARRIS       |  | NATURAL                |  |

BUREAU V. S.

APR 24 1933

RECEIVED

# 4934 CERTIFICATE OF DEATH

Reg. Dist. No.

04874

|  |                               |   |  |  |   |   |   |
|--|-------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>PRINCE GEORGE</u> MARYLAND   |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>MITCHILLVILLE</u>   |                               |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X MITCHILLVILLE</u>                                       |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                               |   |  | d. STREET ADDRESS<br><u>RT 2 BOX 114</u>   |   |   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               |   |  |  |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>BENSON</u> Middle <u>BLAKE</u> Last <u>JR.</u>   |                               |   |  | 4. DATE OF DEATH<br>Month <u>APRIL</u> Day <u>6</u> Year <u>1958</u>   |   |   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>N.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>MARCH 1 1879</u>                                |  | 9. AGE (In years last birthday)<br><u>79</u> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.                                 | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>FARMING</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                               |   |
| 13. FATHER'S NAME<br><u>BENSON BLAKE SR.</u>   |                               |   |  | 14. MOTHER'S MAIDEN NAME<br><u>MARY ELIZABETH MACKALL</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>—</u>   |  | 17. INFORMANT<br><u>LAURA LOUISE BLAKE</u> Address <u>AT 2 BOX 114 MITCHILLVILLE</u>   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 3 yrs<br>DUE TO (c) <u>—</u> |                               |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 MRS</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |   |  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |   |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <u>19</u>  | Month, Day, Year              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)              |   |   |
| 21. I certify that I attended the deceased from <u>DEC. 1, 1955</u> to <u>MARCH, 1958</u> , that I last saw the deceased alive on <u>MARCH 8, 1958</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>3904 ELM ST. UPPER MARLBORO, MD.</u> DATE SIGNED <u>—</u>         |                               |   |  |  |   |   |   |
| ACTUAL SIGNATURE <u>Cornett W. Cadogan Jr.</u>   |                               |   |  |  |   |   |   |
| PHYSICIAN'S NAME (Type) <u>—</u>   |                               |   |  |  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                               | 22b. DATE THEREOF<br><u>4-9-1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Adams Chapel</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Mitchellville, Md</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>William Reese</u> ADDRESS <u>108 W. 4th St. Annapolis, Md</u>   |                               |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 10 '58</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>—</u>                                    |   |

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. PLACE OF DEATH: [illegible]  
9. DATE OF DEATH: [illegible]  
10. SIGNATURE OF REGISTRAR: [illegible]  
11. SIGNATURE OF PHYSICIAN: [illegible]  
12. SIGNATURE OF CLERK: [illegible]

BUREAU V. 5

APR 11 1958

RECEIVED

4877 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                        |  |                             |
|--|------------------------|--|-----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Maryland b. COUNTY St. Marys                           |                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville   |                        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loveville 18x-2   |                             |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4604 -29th Street   |                        | d. STREET ADDRESS Rural  |                             |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Elvie Last Bowles   |                        | 4. DATE OF DEATH April 7 1958  |                             |
| 5. SEX female  | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/22/ 1872 |
| 9. AGE (In years last birthday) 86 yrs.  |                        | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife  |                        | 10b. KIND OF BUSINESS OR INDUSTRY domestic   |                             |
| 11. BIRTHPLACE (State or foreign country) Maryland   |                        | 12. CITIZEN OF WHAT COUNTRY? USA   |                             |
| 13. FATHER'S NAME George U. Hayden   |                        | 14. MOTHER'S MAIDEN NAME Jane Knott  |                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no  |                        | 16. SOCIAL SECURITY NO. -----  |                             |
| 17. INFORMANT Daniel J. Bowles - Loveville, Md.  |                        | Address  |                             |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 450.0 DUE TO GENERALIZED ARTERIOSCLEROSIS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO |                        | INTERVAL BETWEEN ONSET AND DEATH? 20 YRS.?   |                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC OSTEOARTHRITIS   |                        | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                             |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19   |                        | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work   |                             |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                        | 20f. (City or town) (County) (State)   |                             |
| 21. I certify that I attended the deceased from APR. 1, 1958, to APR. 7, 1958, that I last saw the deceased alive on APR. 6, 1958, and that death occurred at 2:40 A.M. from the causes and on the date stated above.  |                        |  |                             |
| ACTUAL SIGNATURE J.E. Bowman M.D.  |                        | ADDRESS (Street, city or town, state) 4021-18TH ST. N.E. WASHINGTON, D.C.  |                             |
| PHYSICIAN'S NAME (Type) J.E. Bowman  |                        | DATE SIGNED 4/7/58   |                             |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |                        | 22b. DATE THEREOF 4/9/58   |                             |
| 22c. NAME OF CEMETERY OR CREMATORY St. Joseph  |                        | 22d. LOCATION (City, town, or county) (State) Morganza, Md.  |                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.  |                        | 24a. REC'D BY REGISTRAR APR 14 '58   |                             |
| 24b. REGISTRAR'S SIGNATURE   |                        |  |                             |

BUREAU V. 3

APR 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4878 CERTIFICATE OF DEATH

Reg. Dist. No.

04876

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Sacred Heart Home</u><br><b>PRINCE GEORGES MARYLAND</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>D. C.</u><br>b. COUNTY <u>WASHINGTON</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HYATTSVILLE</u>   |  | c. LENGTH OF STAY IN IB<br><u>4 years</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>SACRED HEART HOME</u>   |  | d. STREET ADDRESS<br><u>1628 Columbia Rd. N.W.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Daisy E. Brick</u>   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>30</u> Year <u>1958</u>  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-5-69</u>   |
| 9. AGE (In years last birthday)<br><u>88 yrs.</u>  |  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Clerk</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Gov't.</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Washington, D. C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |   |
| 13. FATHER'S NAME<br><u>PATRICK J. BRICK</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>MARGARET SMITH</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.<br><u>SACRED HEART HOME RECORDS</u>  |   |
| 17. INFORMANT<br><u>SACRED HEART HOME RECORDS</u>  |  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE: <u>Peripheral Vascular failure</u><br><u>420.0</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Broncho-pneumonia</u><br>DUE TO<br>(c) <u>Arterio sclerotic heart disease</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hrs</u><br><u>3 days</u><br><u>5 yrs</u>                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>491x</u> <u>Inanition</u>  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <u>  </u> p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  | 20f. (City or town) (County) (State)<br><u>  </u>   |
| 21. I certify that I attended the deceased from <u>March, 1941</u> to <u>4/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/29/58</u> , 19 <u>  </u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.   |  |  |   |
| ACTUAL SIGNATURE<br><u>E. H. Aschenbach</u>  |  | ADDRESS (Street, city or town, state)<br><u>1841 Col Rd NW</u> DATE SIGNED<br><u>4/30/58</u>   |   |
| PHYSICIAN'S NAME (Type)<br><u>E. H. Aschenbach</u>   |  | M.D.   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>5-2-58</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Washington D. C.</u>                          |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Francis J. Collins</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>MAY 5 '58</u>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>  </u>  |  | 24c. REGISTRAR'S SIGNATURE<br><u>  </u>  |   |

MEDICAL CERTIFICATION

I

90

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| NAME OF DECEASED<br>JAMES EARL RAY       |  | SEX<br>MALE                                   |  |
| DATE OF BIRTH<br>JANUARY 5, 1928         |  | AGE<br>32 YEARS                               |  |
| PLACE OF BIRTH<br>MOBILE, ALABAMA        |  | RACE<br>WHITE                                 |  |
| DATE OF DEATH<br>APRIL 4, 1968           |  | TIME OF DEATH<br>2:01 PM                      |  |
| PLACE OF DEATH<br>MEMPHIS, TENNESSEE     |  | COUNTY<br>SHELBY                              |  |
| CAUSE OF DEATH<br>SHOT - GUN             |  | MANNER OF DEATH<br>SUICIDE                    |  |
| MEDICAL HISTORY<br>NO PREVIOUS ILLNESS   |  | OCCASION OF DEATH<br>WHILE ON THE WANTED LIST |  |
| SIGNATURE OF DECEASED<br>JAMES EARL RAY  |  | SIGNATURE OF WITNESS<br>JAMES EARL RAY        |  |
| SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | SIGNATURE OF CORONER<br>JAMES EARL RAY        |  |
| SIGNATURE OF JURY<br>JAMES EARL RAY      |  | SIGNATURE OF JUDGE<br>JAMES EARL RAY          |  |

DO NOT WRITE IN THESE SPACES

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF HIS OR HER DEATH. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT. IT IS TO BE DESTROYED AFTER FIFTY YEARS.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4893

## CERTIFICATE OF DEATH

Reg. Dist. No. 04878

|  |                              |   |                                    |   |   |  |  |
|--|------------------------------|---|------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND  |                              |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |                              |   |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>15 Hyattsville</u>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>Telam Memorial</u>   |                              |   |                                    | e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Charles Earl Brown</u>   |                              |   |                                    | 4. DATE OF DEATH Month Day Year<br><u>4 5 1958</u>  |   |  |  |
| 5. SEX<br><u>m</u>   | 6. COLOR OR RACE<br><u>w</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>2/14/99</u> | 9. AGE (In years lost birthday) yrs.<br><u>59</u>   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Carpenter</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Building</u>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>mat Brown</u>  |                              |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Tamsey Lanter</u>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>578-01-1247</u>   |                                    | 17. INFORMANT Address<br><u>Imogene Lewis - Hanover, Md 870-1</u>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u><br>DUE TO (c) _____ |                              |   |                                    |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 hrs</u><br><u>7 yrs</u>                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |                                    |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                     |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>1951</u> , 19____, to <u>4/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/5</u> , 19 <u>58</u> , and that death occurred at <u>5:00</u> M, from the causes and on the date stated above.   |                              |   |                                    |   |   |  |  |
| ACTUAL SIGNATURE <u>Irving W. Winik</u>  |                              | M.D. <u>3900 McKinley St. N.W.</u>  |                                    |   |   | DATE SIGNED <u>4/5/58</u>  |  |
| PHYSICIAN'S NAME (Type) <u>Irving W. Winik</u>   |                              | <u>Washington, D.C.</u>   |                                    |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                              | 22b. DATE THEREOF<br><u>4-8-58</u>  |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><u>St. Lincoln</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Columbia, Maryland</u>                     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>See Funeral Home 447 Main Ave NE</u>  |                              |   |                                    | ADDRESS   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 10 '58</u>  |  |
|  |                              |   |                                    | 24b. REGISTRAR'S SIGNATURE<br><u>W. E. Smith</u>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

FILE NO.

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>[Faint text]                  |  | 2. SEX<br>[Faint text]                            |  |
| 3. AGE<br>[Faint text]                               |  | 4. DATE OF BIRTH<br>[Faint text]                  |  |
| 5. PLACE OF BIRTH<br>[Faint text]                    |  | 6. OCCUPATION<br>[Faint text]                     |  |
| 7. MARITAL STATUS<br>[Faint text]                    |  | 8. CAUSE OF DEATH<br>[Faint text]                 |  |
| 9. MEDICAL HISTORY<br>[Faint text]                   |  | 10. SIGNATURE OF PHYSICIAN<br>[Faint text]        |  |
| 11. SIGNATURE OF REGISTRAR<br>[Faint text]           |  | 12. SIGNATURE OF WITNESSES<br>[Faint text]        |  |
| 13. SIGNATURE OF DECEASED<br>[Faint text]            |  | 14. SIGNATURE OF NEXT OF KIN<br>[Faint text]      |  |
| 15. SIGNATURE OF BURIAL OFFICIAL<br>[Faint text]     |  | 16. SIGNATURE OF CLERK<br>[Faint text]            |  |
| 17. SIGNATURE OF ASSISTANT CLERK<br>[Faint text]     |  | 18. SIGNATURE OF CHIEF CLERK<br>[Faint text]      |  |
| 19. SIGNATURE OF DEPUTY CHIEF CLERK<br>[Faint text]  |  | 20. SIGNATURE OF SECRETARY<br>[Faint text]        |  |
| 21. SIGNATURE OF ASSISTANT SECRETARY<br>[Faint text] |  | 22. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 23. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 24. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 25. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 26. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 27. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 28. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 29. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 30. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 31. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 32. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 33. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 34. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
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| 43. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 44. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
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| 53. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 54. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
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| 73. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 74. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 75. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 76. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
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| 79. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 80. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 81. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 82. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 83. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 84. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
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| 91. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 92. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 93. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 94. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 95. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 96. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 97. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 98. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]  |  |
| 99. SIGNATURE OF CLERK IN CHARGE<br>[Faint text]     |  | 100. SIGNATURE OF CLERK IN CHARGE<br>[Faint text] |  |

BURIAL V. S.

APR 10 1923

RECEIVED

## CERTIFICATE OF DEATH

04879

Reg. Dist. No.

4873

|   |                                  |   |  |  |   |   |  |
|---|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Prince George's</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>College Park, Md</b>   |                                  |   |  | c. LENGTH OF STAY IN 1b  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>9604 48th Place,</b>   |                                  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Annie</b> Middle <b>Caldwell</b> Last <b>Burnette</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>20</b> , Year <b>1958-</b>   |   |   |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 22 1878</b> |  | 9. AGE (In years and birthday) yrs.<br><b>80 19</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                              |  |
| 13. FATHER'S NAME<br><b>Robert Aitcheson</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Burton</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT<br><b>Robert F. Burnette</b> Address <b>Berwyn Heights, Md.</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br><b>332 X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |   |  |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                      |  |
| 21. I certify that I attended the deceased from <b>APRIL 19, 1958</b> to <b>APRIL 19, 1958</b> , that I last saw the deceased alive on <b>APRIL 19, 1958</b> , and that death occurred at <b>9:20 A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4713-BERWYN Rd</b> DATE SIGNED <b>4/20/58</b>  |                                  |   |  |  |   |   |  |
| ACTUAL SIGNATURE <b>W. L. ETIENNE</b>   |                                  | M.D. <b>W. L. ETIENNE</b>   |  | COLLEGE PARK, MD   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                                  | 22b. DATE THEREOF<br><b>4/22/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Crematory</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Colmar Manor, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 23 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. L. Etienne</b>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 23 1958

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04880

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

Prince Georges MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chesley

c. LENGTH OF STAY IN 1b

dead named

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland b. COUNTY Prince Georges

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Seat Pleasant

d. STREET ADDRESS

6948 Central Ave

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒3. NAME OF  
DECEASED  
(Type or print)

James Melvin Chaney

4. DATE  
OF DEATH

April 11 1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

April 28, 1928

9. AGE (In years  
last birthday)

29 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plasterer Empl'd

10b. KIND OF BUSINESS OR INDUSTRY

Construct

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

James Melvin Chaney

14. MOTHER'S MAIDEN NAME

Ruth Marie Fitzsimmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Dolores Marie Gray

Address 604 5th Rd

Upper Marlboro

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

823x

DUE TO

Hemorrhage and shock

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Crushed chest, fracture skull

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Rear of auto that ran over and struck head

20c. TIME OF INJURY

8:00 a.m.

Month, Day, Year

4-11 1958

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)

Central Avenue

20f. (City or town)

Halls

(County)

P. G. Co.

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

James I. Boyd

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

April 12, 1958

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/15/58

22c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

22d. LOCATION (City, town, or county)

Suitland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Ritchie Brothers Funeral Home

ADDRESS

Upper Marlboro, Md.

24a. REC'D BY REGISTRAR

APR 21 '58

24b. REGISTRAR'S SIGNATURE

W. H. Beach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
LABORATORY EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT  
IN

BUREAU V. S.

APR 21 1959

RECEIVED

4895

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b><br>c. LENGTH OF STAY IN 1b<br><b>10 Hrs 20 Min</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General</b>         |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville, 15</b><br>d. STREET ADDRESS<br><b>7315 Forest Rd.,</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Baby Boy Charlton</b>  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>April 26 19 58</b>  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>April 26, 58</b>                    |  |
| 9. AGE (In years lost birthday) yrs.<br><b>10 20</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>P.G.Co., Md.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>Perry Charlton</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Barbara Ann Bergman</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Parents</b>  |  | Address<br><b>Same as above</b>                            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>762.5 Pulm. Emphy.</b><br>DUE TO (b) <b>Primary Arterio Sclerosis</b><br>DUE TO (c) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                           |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                       |  |
| 21. I certify that I attended the deceased from <b>4/26 19 58</b> to <b>4/26 19 58</b> , that I last saw the deceased alive on <b>4/26 19 58</b> , and that death occurred at <b>7:00 P.M.</b> , from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John Perkins</b>  |  |  |  | ADDRESS (Street, city or town, state)<br><b>5301 Hamilton St., Hyattsville, Md.</b>  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>John Perkins, M. D.</b>  |  |  |  | DATE SIGNED<br><b>4/26/58</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |  | 22b. DATE THEREOF<br><b>5/5/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Prince Georges General Hospital, Cheverly, Md.</b>  |  | 22d. LOCATION (City, town, or county) (State)              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harry W. Penn, Jr., Administrator</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br><b>DATE MAY 7 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Alb. Smith</b>            |  |

2077251XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

# 4935 CERTIFICATE OF DEATH

04882

Reg. Dist. No.

|  |  |  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Prince George's</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIVERSITY PARK</u><br>c. LENGTH OF STAY IN TB<br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6308 Queens Chapel Rd</u>                      |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Park</u><br>d. STREET ADDRESS <u>6308 Queens Chapel Road</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>ROSE</u> First <u>A</u> Middle <u>CLARKE</u> Last   |  | <b>4. DATE OF DEATH</b><br><u>APRIL</u> Month <u>13</u> Day <u>1958</u> Year |  | <b>5. SEX</b><br><u>FEMALE</u>   |  | <b>6. COLOR OR RACE</b><br><u>WHITE</u>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>Aug 15 1872</u> |  | <b>9. AGE</b> (In years) <u>85</u> yrs.<br>IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____<br>IF UNDER 24 HRS. _____ |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>VA.</u>   |  |   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>U. S. A.</u>   |  |   |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>MICHAEL CLARKE</u>  |  |  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>CATHERINE BYRNE</u>   |  |   |  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)  |  |  |  | <b>16. SOCIAL SECURITY NO.</b>   |  |   |  | <b>17. INFORMANT</b> Address _____  |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Exhaustion</u><br>DUE TO (b) <u>Diffuse Carcinomatosis</u><br>DUE TO (c) <u>Adenocarcinoma of Ovary</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) |  |   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. _____ 19____   |  |  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)                       |  | <b>20f. (City or town)</b> (County) (State)   |  |   |  |  |  |
| <b>21. I certify that I attended the deceased from</b> <u>Feb</u> <u>1955</u> , to <u>April 13, 1958</u> , that I last saw the deceased alive on <u>April 13, 1958</u> and that death occurred at <u>5:10 p.m.</u> from the causes and on the date stated above.   |  |  |  |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>William L. Howell</u> M.D. ADDRESS (Street, city or town, state) <u>3562 Macomb St N.W. Washington 16 D.C.</u>   |  |  |  |  |  | DATE SIGNED _____   |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>William L. Howell</u>   |  |  |  |  |  | <u>Washington 16 D.C.</u>   |  |   |  |   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>4-16-58</u>  |  |  |  | <b>22b. DATE THEREOF</b>   |  |   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt Olivet Cem.</u>   |  |   |  | <b>22d. LOCATION</b> (City, town, or county) (State) <u>Bladensburg Rd Wash D.C.</u>   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Larson</u> ADDRESS <u>Wash. D. C.</u>   |  |  |  |  |  | <b>24a. REC'D BY REGISTRAR</b> DATE <u>APR 15 58</u>  |  | <b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>  |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and registrar details. The form is oriented horizontally but contains vertical text elements.

RECEIVED  
APR 15 1958  
BUREAU V. R.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4896 CERTIFICATE OF DEATH

Reg. Dist. No. 04883

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Prince Georges</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>11 days</b>   |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Louis</b> Middle <b>Cohen</b> Last <b>Cohen</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>30</b> Year <b>1958</b>   |                                    |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>71</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocer</b>  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Russian</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |
| 13. FATHER'S NAME<br><b>Jehuda</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Jaeka</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>Ms Ida Lavone - same</b>  |                                    |
| 17. INFORMANT<br><b>Ms Ida Lavone</b>  |                                  | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Left ventricular failure</b><br>DUE TO <b>Cerebral Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO <b>HYPERTENSIVE ARTERIO SCLEROTIC HEART DISEASE</b><br>(c) <b>Diabetic Acidosis?</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>11 days</b><br><b>4 days</b><br><b>20 yo?</b>  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>260X</b>   |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I attended the deceased from <b>1956</b> , 19, to <b>4/30/58</b> , 19, that I last saw the deceased alive on <b>4-30-58</b> , 19, and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.   |                                  |   |                                    |
| ACTUAL SIGNATURE<br><b>David S Clayman</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>6311 Balto. Ave - Riverdale Md</b>  |                                    |
| DATE SIGNED<br><b>4/30/58</b>  |                                  |   |                                    |
| PHYSICIAN'S NAME (Type)<br><b>Dr. David S Clayman M.D.</b>   |                                  |   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>5-1-58</b>  |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Run</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Jack Lewis</b>  |                                  | ADDRESS<br><b>2100 Canton Road</b>  |                                    |
| 24a. REC'D BY REGISTRAR<br><b>MAY 1 '58</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>W. Lewis</b>   |                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04884

Reg. Dist. No.

1936

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with permit PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince Georges                      |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill   |  | c. LENGTH OF STAY IN 1b 35 years   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Chapel Hill   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8709 Livingston Rd SE   |  |  |  | d. STREET ADDRESS 8709 Livingston Rd SE  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) Catherine Anne Colbert   |  |  |  | 4. DATE OF DEATH April 26 1958   |  |  |  |
| 5. SEX Female  |  | 6. COLOR OR RACE Calred  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH Sept 6, 1888  |  |
| 9. AGE (In years last birthday) 69 yrs.  |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife  |  | 10b. KIND OF BUSINESS OR INDUSTRY Gun House  |  | 11. BIRTHPLACE (State or foreign country) Maryland   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 13. FATHER'S NAME Alfred Warrick   |  |  |  | 14. MOTHER'S MAIDEN NAME Catherine Scott   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No  |  | 16. SOCIAL SECURITY NO. none   |  | 17. INFORMANT William Thomas Colbert, same as the  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 442X Congestive heart failure<br>DUE TO (b) Cardiovascular renal disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)     |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19   |  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE James I. Boyd   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| EXAMINER'S NAME (Type) James I. Boyd   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
|  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 26, 1958   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  | 22b. DATE THEREOF April 30, 1958   |  | 22c. NAME OF CEMETERY OR CREMATORY Church Cemetery   |  | 22d. LOCATION (City, town, or county) (State) Chapel Hill, Md.                                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W.   |  |  |  | 24a. REC'D BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE   |  |
|  |  |  |  | DATE APR 26 58   |  | Aut. Branch  |  |

FOR STATE  
HEALTH DEPT

RECEIVED  
APR 28 1938  
BUREAU V. S.

## 4937 CERTIFICATE OF DEATH

04885

Reg. Dist. No.

|   |                                  |   |                                    |   |   |  |  |
|---|----------------------------------|---|------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mary</b> West Va b. COUNTY <b>Mercer</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lanham Md</b>  |                                  |   |                                    | c. LENGTH OF STAY IN 1b<br><b>9 months</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>9005 2th Street</b>  |                                  |   |                                    | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prinston</b> <b>85x-3</b> ✓                            |   |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                    |   |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Ada Lelia Cook</b>  |                                  |   |                                    | 4. DATE OF DEATH<br>Month Day Year<br><b>April 19, 19 58</b>  |   |  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 30</b> | 9. AGE (In years last birthday) yrs.<br><b>31</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.                         | IF UNDER 24 HRS.<br>Months Days Hours Min.                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Photographer</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b> |
| 13. FATHER'S NAME<br><b>William F. Willis</b>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Massie</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>234 10 9206</b>   |                                    | 17. INFORMANT<br><b>James H Willis Lanham Md.</b>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Obstruction</b><br><b>171x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic Carcinoma of Cervix</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____         |                                  |   |                                    |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>? Months</b>  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                    |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  |   |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|   |                                  |   |                                    | 20f. (City or town) (County) (State)  |   |  |  |
| 21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>57</b> , to <b>April</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>April 19</b> , 19 <b>58</b> , and that death occurred at <b>7:30 P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>2244 WASHINGTON AVE</b> DATE SIGNED <b>4/20/58</b><br>ACTUAL SIGNATURE <b>Jerome H. Epstein</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>JEROME H. EPSTEIN</b> <b>Silver Spring, Md</b> |                                  |   |                                    |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4/22/58</b>   |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Whitfield Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Lanham Md.</b>     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b>  |                                  |   |                                    | ADDRESS<br><b>Hyattsville Md</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 23 '58</b>                      |  |
|   |                                  |   |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. Beach</b>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                     |  |                        |  |
|---------------------|--|------------------------|--|
| PLACE OF DEATH      |  | DATE OF DEATH          |  |
| HOME                |  | APR 23 1958            |  |
| COUNTY OF DEWITT    |  | STATE OF MARYLAND      |  |
| DECEASED'S NAME     |  | SEX                    |  |
| JOHN J. DEWITT      |  | MALE                   |  |
| AGE                 |  | RACE                   |  |
| 65                  |  | WHITE                  |  |
| MARRIED             |  | OCCUPATION             |  |
| YES                 |  | FARMER                 |  |
| CAUSE OF DEATH      |  | MANNER OF DEATH        |  |
| HEART DISEASE       |  | NATURAL                |  |
| IMMEDIATE CAUSE     |  | INTERMEDIATE CAUSE     |  |
| CORONARY THROMBOSIS |  | HYPERTENSION           |  |
| PREVIOUS ILLNESS    |  | PREVIOUS SURGERY       |  |
| NONE                |  | NONE                   |  |
| SIGNS AND SYMPTOMS  |  | POSTMORTEM EXAMINATION |  |
| PAIN IN CHEST       |  | NONE                   |  |
| DYSNOEIA            |  | NONE                   |  |
| HEMIPARESIS         |  | NONE                   |  |
| CONVULSIONS         |  | NONE                   |  |
| PUPILS              |  | REFLEXES               |  |
| NORMAL              |  | NORMAL                 |  |
| TEMPERATURE         |  | PULSE                  |  |
| 98.6                |  | 60                     |  |
| BLOOD PRESSURE      |  | RESPIRATION            |  |
| 120/80              |  | 16                     |  |
| URINE               |  | FECES                  |  |
| NORMAL              |  | NORMAL                 |  |
| AUTOPSY             |  | BURIAL                 |  |
| NO                  |  | YES                    |  |
| DATE OF BURIAL      |  | PLACE OF BURIAL        |  |
| APR 25 1958         |  | CATHOLIC CHURCH        |  |
| NAME OF MINISTER    |  | NAME OF FUNERAL HOME   |  |
| JOHN J. DEWITT      |  | JOHN J. DEWITT         |  |
| DATE OF DEATH       |  | DATE OF BURIAL         |  |
| APR 23 1958         |  | APR 25 1958            |  |

RECEIVED  
BUREAU V. S.  
APR 23 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4938

## CERTIFICATE OF DEATH

04886

Reg. Dist. No.

|   |                           |   |                                   |
|---|---------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Maryland. b. COUNTY Pr. George's                          |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hill Crest Heights  |                           | c. LENGTH OF STAY IN 1b<br>1- Year  |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>2618- Iverson St. S. E.  |                           | d. STREET ADDRESS<br>2618- Iverson Street S.E.  |                                   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First HARVEY Middle E. Last COOPER  |                           | 4. DATE OF DEATH<br>Month April 5th. Day 19 58  |                                   |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Nov. 15- 1927 |
| 9. AGE (In years last birthday)<br>30 yrs.  |                           | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Service Manager  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Gestetner Duplicator Corp. Canada  |                                   |
| 11. BIRTHPLACE (State or foreign country)<br>Canada   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>Canada ✓  |                                   |
| 13. FATHER'S NAME<br>Ernest Cooper  |                           | 14. MOTHER'S MAIDEN NAME<br>Bertha Kading   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |                           | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |                                   |
| 17. INFORMANT<br>Dorothy E. Cooper ( Wife )   |                           | Address<br>Same as # 2.   |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 163X <u>Circumstances of being with</u><br>DUE TO <u>generalized metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 months</u><br>DUE TO (c)  |                           | INTERVAL BETWEEN ONSET AND DEATH<br>6 months  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that I attended the deceased from Aug 1957, to April 5, 1958, that I last saw the deceased alive on 4-4-1958, and that death occurred at 4:35 AM, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE David S. Gordon, M.D. 5731-23rd Parkway S.E. 4/5/58<br>PHYSICIAN'S NAME (Type) DAVID S. GORDON 5731- 23rd. Parkway Hill Crest Heights, Md. |                           |   |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 22b. DATE THEREOF<br>April 7- 1958  |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY<br>Oakwood Cemetery  |                           | 22d. LOCATION (City, town, or county) (State)<br>Falls Church, Virginia   |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Simmons Brothers  |                           | 24a. REC'D BY REGISTRAR<br>DATE APR 7 '58   |                                   |
| 24b. REGISTRAR'S SIGNATURE<br>W. Leach  |                           |   |                                   |

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>[Illegible]       |  | 2. SEX<br>[Illegible]                    |  |
| 3. AGE<br>[Illegible]                    |  | 4. DATE OF BIRTH<br>[Illegible]          |  |
| 5. PLACE OF BIRTH<br>[Illegible]         |  | 6. OCCUPATION<br>[Illegible]             |  |
| 7. MARITAL STATUS<br>[Illegible]         |  | 8. CAUSE OF DEATH<br>[Illegible]         |  |
| 9. PLACE OF DEATH<br>[Illegible]         |  | 10. DATE OF DEATH<br>[Illegible]         |  |
| 11. SIGNATURE OF DECEASED<br>[Illegible] |  | 12. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 13. SIGNATURE OF DECEASED<br>[Illegible] |  | 14. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 15. SIGNATURE OF DECEASED<br>[Illegible] |  | 16. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 17. SIGNATURE OF DECEASED<br>[Illegible] |  | 18. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 19. SIGNATURE OF DECEASED<br>[Illegible] |  | 20. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 21. SIGNATURE OF DECEASED<br>[Illegible] |  | 22. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 23. SIGNATURE OF DECEASED<br>[Illegible] |  | 24. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 25. SIGNATURE OF DECEASED<br>[Illegible] |  | 26. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 27. SIGNATURE OF DECEASED<br>[Illegible] |  | 28. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 29. SIGNATURE OF DECEASED<br>[Illegible] |  | 30. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 31. SIGNATURE OF DECEASED<br>[Illegible] |  | 32. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 33. SIGNATURE OF DECEASED<br>[Illegible] |  | 34. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 35. SIGNATURE OF DECEASED<br>[Illegible] |  | 36. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 37. SIGNATURE OF DECEASED<br>[Illegible] |  | 38. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 39. SIGNATURE OF DECEASED<br>[Illegible] |  | 40. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 41. SIGNATURE OF DECEASED<br>[Illegible] |  | 42. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 43. SIGNATURE OF DECEASED<br>[Illegible] |  | 44. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 45. SIGNATURE OF DECEASED<br>[Illegible] |  | 46. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 47. SIGNATURE OF DECEASED<br>[Illegible] |  | 48. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 49. SIGNATURE OF DECEASED<br>[Illegible] |  | 50. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 51. SIGNATURE OF DECEASED<br>[Illegible] |  | 52. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 53. SIGNATURE OF DECEASED<br>[Illegible] |  | 54. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 55. SIGNATURE OF DECEASED<br>[Illegible] |  | 56. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 57. SIGNATURE OF DECEASED<br>[Illegible] |  | 58. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 59. SIGNATURE OF DECEASED<br>[Illegible] |  | 60. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 61. SIGNATURE OF DECEASED<br>[Illegible] |  | 62. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 63. SIGNATURE OF DECEASED<br>[Illegible] |  | 64. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 65. SIGNATURE OF DECEASED<br>[Illegible] |  | 66. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 67. SIGNATURE OF DECEASED<br>[Illegible] |  | 68. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 69. SIGNATURE OF DECEASED<br>[Illegible] |  | 70. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 71. SIGNATURE OF DECEASED<br>[Illegible] |  | 72. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 73. SIGNATURE OF DECEASED<br>[Illegible] |  | 74. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 75. SIGNATURE OF DECEASED<br>[Illegible] |  | 76. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 77. SIGNATURE OF DECEASED<br>[Illegible] |  | 78. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 79. SIGNATURE OF DECEASED<br>[Illegible] |  | 80. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 81. SIGNATURE OF DECEASED<br>[Illegible] |  | 82. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 83. SIGNATURE OF DECEASED<br>[Illegible] |  | 84. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 85. SIGNATURE OF DECEASED<br>[Illegible] |  | 86. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 87. SIGNATURE OF DECEASED<br>[Illegible] |  | 88. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 89. SIGNATURE OF DECEASED<br>[Illegible] |  | 90. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 91. SIGNATURE OF DECEASED<br>[Illegible] |  | 92. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 93. SIGNATURE OF DECEASED<br>[Illegible] |  | 94. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 95. SIGNATURE OF DECEASED<br>[Illegible] |  | 96. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 97. SIGNATURE OF DECEASED<br>[Illegible] |  | 98. SIGNATURE OF WITNESS<br>[Illegible]  |  |
| 99. SIGNATURE OF DECEASED<br>[Illegible] |  | 100. SIGNATURE OF WITNESS<br>[Illegible] |  |

RECEIVED  
APR 7 1958  
BUREAU V. S.

James B. Butler

4879

**CERTIFICATE OF DEATH**

Reg. Dist. No.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville Md</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>7 years</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>713 Chillum Road</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <b>C I A R A</b>   |  |   |  | <b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>12</b> , Year <b>1958</b>   |  |  |  |
| <b>5. SEX</b><br><b>female</b>  |  | <b>6. COLOR OR RACE</b><br><b>white</b>                                 |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><b>May 20, 1907</b>   |  |
| <b>9. AGE</b> (In years last birthday) <b>51</b> yrs.   |  | <b>IF UNDER 1 YEAR</b> Months Days Hours Min.                           |  | <b>IF UNDER 24 HRS.</b>   |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Administrative Office</b> |  |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>U S Government</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Pennsylvania</b> |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U S A</b>   |  |  |  |
| <b>13. FATHER'S NAME</b><br><b>George P Cramer</b>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Jennie Farnum</b>   |  |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>   |  | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT</b> <b>65 Laurel Drive</b><br><b>Nanette D Craig</b> <b>FairHaven New Jersey</b>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease</b><br><b>416X</b> DUE TO <b>with congestive failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO (c) _____ |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary arteriosclerosis</b>  |  |   |  |   |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  |  |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  |
| <b>20f. (City or town)</b> (County) (State)   |  |   |  | <b>21. I certify that I attended the deceased from</b> <b>1/20, 1954</b> to <b>4/12, 1958</b> that I last saw the deceased alive on <b>4/10, 1958</b> , and that death occurred at <b>9:55 A.M.</b> from the causes and on the date stated above. |  |  |  |
| <b>ADDRESS</b> (Street, city or town, state) <b>1746 K. S. A. W.</b>  |  |   |  | <b>DATE SIGNED</b> <b>4/12/58</b>   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <b>S. W. Nealon Jr</b> M.D.   |  |   |  |   |  |  |  |
| <b>PHYSICIAN'S NAME</b> (Type) <b>S W Nealon Jr</b> <b>Washington D. C.</b>   |  |   |  |   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>   |  | <b>22b. DATE THEREOF</b><br><b>4/15/58</b>                              |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Cannan Corners Cemetery</b>   |  | <b>22d. LOCATION</b> (City, town, or county) (State)<br><b>Waymart Pennsylvania</b>  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F. Gasch's Sons</b> <b>Hyattsville Md.</b>   |  |   |  | <b>24a. REC'D BY REGISTRAR</b> <b>APR 16 58</b>   |  | <b>24b. REGISTRAR'S SIGNATURE</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Coroner notified  
+ approved  
Sum.

BUREAU V. S.

APR 16 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4880

CERTIFICATE OF DEATH

04888

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>   |                                  | c. LENGTH OF STAY IN 1b <u>15</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Home</u>   |                                  | d. STREET ADDRESS <u>5805 Queens Chapel Rd</u>  |   |
| 3. NAME OF DECEASED (Type or print) <u>M. Helena</u> First <u>Dement</u> Middle Last  |                                  | 4. DATE OF DEATH <u>April 13</u> Month Day Year <u>1958</u>   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH <u>4/14/66</u>                                     |
| 9. AGE (In years at birthday) <u>92</u> yrs.  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Printing Office</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Charles Co. 7nd</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |   |
| 13. FATHER'S NAME <u>William F. Dement</u>  |                                  | 14. MOTHER'S MAIDEN NAME <u>Mary S. Green</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO. <u>Marie L. Hatchford</u>   |   |
| 17. INFORMANT <u>Mr. Rainier, Md.</u>   |                                  | Address <u>3720-35th St.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Peripheral Vascular failure</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerosis</u> DUE TO<br>(c) <u>Anemia - nutritional</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u><br><u>25+ yrs.</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia - nutritional</u>   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <u>9</u> p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>12/15</u> , 19 <u>58</u> , to <u>4/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/13/58</u> , 19 <u>58</u> , and that death occurred at <u>12</u> <u>10</u> M., from the causes and on the date stated above.  |                                  |   |   |
| ACTUAL SIGNATURE <u>E. H. Aschenbach</u>  |                                  | ADDRESS (Street, city or town, state) <u>1841 Cal Rd NW</u>   |   |
| PHYSICIAN'S NAME (Type) <u>E. H. Aschenbach, M.D.</u>   |                                  | DATE SIGNED   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>4/15/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>   | 22d. LOCATION (City, town, or county) (State) <u>Washington, DC</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>   |                                  | ADDRESS <u>Mt. Rainier Md.</u>  |   |
| 24a. REC'D BY REGISTRAR <u>APR 16 1958</u>  |                                  | 24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>   |   |

APR 16 1958

RECEIVED

4897 CERTIFICATE OF DEATH

04889

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George's.</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Riverdale</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>25 Riverdale</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>4603 Riverdale Rd.</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Diggs</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>25</u> Year <u>19 58</u>  |  |  |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>white</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Feb. 1, 1888</u>                                |  |
| 9. AGE (In years last birthday) yrs.<br><u>70</u>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>At Home</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore Md.</u>      |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><u>Henry J. Ritterbusch</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Margaret Lechthaler</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Mrs. George Edge</u>                               |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u><br><u>334X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.<br>(b) <u>Cerebral arterio-sclerosis</u><br>DUE TO<br>(c) <u>Generalized arterio-sclerosis</u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Day</u><br><u>2-3 wks</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <u>April 15, 1958</u> , to <u>April 25, 1958</u> , that I last saw the deceased alive on <u>April 24, 1958</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>4713 Berron Rd., College Park, Maryland</u><br>DATE SIGNED <u>4/25/58</u>                         |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Wolcott L. Etienne</u> M.D.  |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Wolcott L. Etienne, M.D.</u>  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>4/28/58</u>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Lawn</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore Md.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Blumenfeld</u> ADDRESS <u>3218 Hudson St.</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 29 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Adel Smith</u>                        |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                        |  |                        |  |
|------------------------|--|------------------------|--|
| NAME OF DECEASED       |  | DATE OF DEATH          |  |
| PLACE OF DEATH         |  | CITY OF DEATH          |  |
| CAUSE OF DEATH         |  | MANNER OF DEATH        |  |
| DATE OF BIRTH          |  | AGE                    |  |
| SEX                    |  | RACE                   |  |
| EDUCATION              |  | OCCUPATION             |  |
| MARITAL STATUS         |  | RELIGION               |  |
| PREVIOUS ILLNESS       |  | HISTORY OF DEATH       |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  |
| DATE OF SIGNATURE      |  | DATE OF SIGNATURE      |  |
| PLACE OF SIGNATURE     |  | PLACE OF SIGNATURE     |  |
| NAME OF PHYSICIAN      |  | NAME OF REGISTRAR      |  |
| ADDRESS OF PHYSICIAN   |  | ADDRESS OF REGISTRAR   |  |
| PHONE OF PHYSICIAN     |  | PHONE OF REGISTRAR     |  |
| FEE PAID               |  | FEE PAID               |  |
| REMARKS                |  | REMARKS                |  |

BUREAU Y. 3

APR 29 1958

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 04890

4939

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Maryland b. COUNTY Prince Georges                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB  |  | c. LENGTH OF STAY IN 1b DOA  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) DOA on Arrival 1001st USAF Hospital, Andrews AFB  |  | d. STREET ADDRESS Lot #28, Trailer Park Andrews AF Base, Wash. 25, D.C.  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last Walter Carl Dills III   |  | 4. DATE OF DEATH Month Day Year April 12 19 58   |  |
| 5. SEX Male   | 6. COLOR OR RACE Cau   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 April 1950                               |
| 9. AGE (In years last birthday) yrs. 8  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Applicable  |  | 10b. KIND OF BUSINESS OR INDUSTRY Not Applicable   |  |
| 11. BIRTHPLACE (State or foreign country) Okla. City, Okla.   |  | 12. CITIZEN OF WHAT COUNTRY? United States   |  |
| 13. FATHER'S NAME Walter C. Dills Jr. II  |  | 14. MOTHER'S MAIDEN NAME Mary Lou Work   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No   |  | 16. SOCIAL SECURITY NO. -  |  |
| 17. INFORMANT Walter C. Dills Jr. Father  |  | Lot #28, Trailer Park, Andrews AFB, Wash 25, D.C.  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Degenerative disease of the Nervous System<br>355X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) |  |  | INTERVAL BETWEEN ONSET AND DEATH Since Birth                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                         |
| 21. I certify that I attended the deceased from 12 April, 19 58, to 12 April, 19 58, that I last saw the deceased alive on See Reverse Side, and that death occurred at M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED                               |  |  |  |
| ACTUAL SIGNATURE  |  | M.D. 1001st USAF Hospital 12 April 1958  |  |
| PHYSICIAN'S NAME (Type) JOHN W. SNOW CAPT USAF (MC)   |  | Andrews AF Base, Washington 25, D.C.   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  | 22b. DATE THEREOF 16 April 1958  | 22c. NAME OF CEMETERY OR CREMATORY Arlington National  | 22d. LOCATION (City, town, or county) (State) Arlington, Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  |  | 24a. REC'D BY REGISTRAR  | 24b. REGISTRAR'S SIGNATURE                                   |
| Rinaldi Funeral Home, Inc. 816 H St. NE Wash, DC  |  | DATE APR 16 '58  |  |

MEDICAL CERTIFICATION

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99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

12 April 1958: Deceased arrived at 1001st USAF Hospital, Andrews Air Force Base, Washington 25, D.C. At approximately 1000 AM, 12 April 1958.

I certify that deceased was D&A and I Confirmed same at approximately 1000 AM, 12 April 1958.

D C Coroner notified and did approve

BUREAU V. S.

APR 17 1958

RECEIVED

## 4898 CERTIFICATE OF DEATH

04891

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Prince Georges</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>2 hrs</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>25 E Riverdale</b>  |                                  | d. STREET ADDRESS<br><b>5600 56th Ave</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Baby Boy</b> Middle <b>(Paul William)</b> Last <b>Drake</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>1</b> Year <b>19 58</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>* 1 April 58</b> |
| 9. AGE (In years last birthday) yrs.<br><b>2</b>   |                                  | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>15</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None--Infant</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Daniel Drake</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Olga Pozyski</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Daniel D. Drake, 5600--56th Street, East Riverdale, Md.</b>  |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Congenital Defects</b><br><b>759.3</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hours</b> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>4-1-58</b> , 19____, to <b>4-1-58</b> , 19____, that I last saw the deceased alive on <b>4-1-58</b> , 19____, and that death occurred at <b>11:00A</b> M, from the causes and on the date stated above. |                                  |  |   |
| ACTUAL SIGNATURE<br><b>Albert Roth</b>   |                                  | ADDRESS (Street, city or town, state) <b>4-1-58</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Albert Roth M D</b>  |                                  | DATE SIGNED<br><b>4-1-58</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4/7/1958</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l Cem.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W W Chambers</b>  |                                  | ADDRESS<br><b>Riverdale</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>APR 7 '58</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Quinn</b>   |   |

2077323 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 7 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

04892

4940

|   |                                |  |  |
|---|--------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Prince George</i> MARYLAND  |                                | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Upper Marlboro</i>   |                                | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>x Upper Marlboro Rural</i>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                | d. STREET ADDRESS<br><i>111</i>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Leo</i> Middle <i>L.</i> Last <i>Edelen</i>   |                                | 4. DATE OF DEATH<br>Month <i>April</i> Day <i>6</i> Year <i>1958</i>   |  |
| 5. SEX <i>M</i>   | 6. COLOR OR RACE <i>Cobalt</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>June 8, 1895</i>    |
| 9. AGE (In years last birthday) <i>62</i> yrs.  |                                | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Servant</i>   |                                | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Farming</i>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Newport Md.</i>   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 13. FATHER'S NAME<br><i>Sam Edelen</i>  |                                | 14. MOTHER'S MAIDEN NAME<br><i>Julia Farmer</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                                | 16. SOCIAL SECURITY NO.<br><i>216-18-5706</i>  |  |
| 17. INFORMANT<br><i>Mrs. Mary Jane Edelen</i>   |                                | Address<br><i>Upper Marlboro</i>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i><br><i>442x</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Hypertensive Cardio-Vascular</i><br>DUE TO (c) <i>Renal Disease</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i><br>INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>2 years</i> |                                |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i>None</i>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>  |                                | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <i>Mar 1</i> , 19 <i>58</i> , to <i>Apr 6</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Apr 6</i> , 19 <i>58</i> , and that death occurred at <i>7:30 P.M.</i> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><i>Upper Marlboro, Md.</i>   |                                |  |  |
| ACTUAL SIGNATURE <i>James B. Sasser</i> M.D.  |                                | PHYSICIAN'S NAME (Type) <i>James B. Sasser M.D.</i>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |                                | 22b. DATE THEREOF<br><i>4/10/58</i>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><i>St Ignatius</i>  |                                | 22d. LOCATION (City, town, or county) (State)<br><i>Bel Alton, Md.</i>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Hunt Funeral Home, Waldorf, Md.</i>  |                                | 24a. REC'D BY REGISTRAR<br>DATE <i>APR 11 '58</i>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><i>Quinn</i>  |                                |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                        |  |                              |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |
|------------------------|--|------------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED       |  | SEX                          |  | AGE                  |  | DATE OF BIRTH        |  | PLACE OF BIRTH       |  | CITY                 |  | STATE                |  | COUNTRY              |  |
| JAMES EARL RAY         |  | MALE                         |  | 35                   |  | JAN 5 1928           |  | MOBILE               |  | ALABAMA              |  | UNITED STATES        |  | UNITED STATES        |  |
| OCCUPATION             |  | CAUSE OF DEATH               |  | MANNER OF DEATH      |  | PERIOD OF ILLNESS    |  | DATE OF DEATH        |  | PLACE OF DEATH       |  | CITY                 |  | STATE                |  |
| SALES MAN              |  | HEART DISEASE                |  | SUICIDE              |  | 2 WEEKS              |  | APR 4 1968           |  | MEMPHIS              |  | TENNESSEE            |  | UNITED STATES        |  |
| PREVIOUS ILLNESS       |  | TREATMENT                    |  | HISTORY              |  | FAMILY HISTORY       |  | SOCIAL HISTORY       |  | RELIGION             |  | EDUCATION            |  | MARRIAGE             |  |
| NONE                   |  | NONE                         |  | NONE                 |  | NONE                 |  | NONE                 |  | NONE                 |  | HIGH SCHOOL          |  | MARRIED              |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF DEATH REGISTRAR |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  |
| [Signature]            |  | [Signature]                  |  | [Signature]          |  | [Signature]          |  | [Signature]          |  | [Signature]          |  | [Signature]          |  | [Signature]          |  |
| DATE                   |  | TIME                         |  | PLACE                |  | CITY                 |  | STATE                |  | COUNTRY              |  | CITY                 |  | STATE                |  |
| APR 4 1968             |  | 10:00 AM                     |  | MEMPHIS              |  | TENNESSEE            |  | UNITED STATES        |  | UNITED STATES        |  | MEMPHIS              |  | TENNESSEE            |  |

BUREAU V. S.

APR 11 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4941 CERTIFICATE OF DEATH

04893

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George's |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Maryland  |  | c. LENGTH OF STAY IN 1b 3 weeks  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eleven Cedars Nursing Home  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Berwyn Heights,                                   |  |
| 4. DATE OF DEATH<br>Month April Day 25 Year 19 58  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 3. NAME OF DECEASED (Type or print)<br>First Mabel Middle Ellis Last Ellis   |  | 4. DATE OF DEATH<br>Month April Day 25 Year 19 58  |  |
| 5. SEX female  |  | 6. COLOR OR RACE white   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH 4/26/70   |  |
| 9. AGE (In years last birthday) 87 yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk  |  | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.   |  |
| 11. BIRTHPLACE (State or foreign country) Kentucky   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 13. FATHER'S NAME Hezakiah Ellis   |  | 14. MOTHER'S MAIDEN NAME Anna Mary Stoughton   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. none   |  |
| 17. INFORMANT Roe Anderson - 6216 Quebec Pl. Berwyn Heights, Md.   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 332X Cerebral arterio-sclerosis with infarction<br>DUE TO (b) Generalized arterio-sclerosis.<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work                               |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from April 4, 1958, to April 25, 1958, that I last saw the deceased alive on April 25, 1958, and that death occurred at 3:00 P.M. from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE Wolcott L. Etienne M.D.   |  | ADDRESS (Street, city or town, state) 4713 Berwyn Road, DATE SIGNED 4/25/58  |  |
| PHYSICIAN'S NAME (Type) Wolcott L. Etienne, M.D.   |  | College Park, Maryland   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   |  | 22b. DATE THEREOF 4/28/58  |  |
| 22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY   |  | 22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey  |  | ADDRESS SILVER SPRING, MD.   |  |
| 24a. REC'D BY REGISTRAR DATE APR 30 '58  |  | 24b. REGISTRAR'S SIGNATURE   |  |

CERTIFICATE OF DEATH

0041

|  |  |   |  |                                       |  |   |  |
|--|--|---|--|---------------------------------------|--|---|--|
| 1. NAME OF DECEASED<br>[Illegible]       |  | 2. SEX<br>[Illegible]                   |  | 3. AGE<br>[Illegible]                 |  | 4. DATE OF BIRTH<br>[Illegible]           |  |
| 5. PLACE OF BIRTH<br>[Illegible]         |  | 6. OCCUPATION<br>[Illegible]            |  | 7. MARITAL STATUS<br>[Illegible]      |  | 8. COLOR<br>[Illegible]                   |  |
| 9. DATE OF DEATH<br>[Illegible]          |  | 10. TIME OF DEATH<br>[Illegible]        |  | 11. PLACE OF DEATH<br>[Illegible]     |  | 12. CAUSE OF DEATH<br>[Illegible]         |  |
| 13. MEDICAL HISTORY<br>[Illegible]       |  | 14. PRESENT ILLNESS<br>[Illegible]      |  | 15. TREATMENT<br>[Illegible]          |  | 16. SIGNATURE OF PHYSICIAN<br>[Illegible] |  |
| 17. SIGNATURE OF DECEASED<br>[Illegible] |  | 18. SIGNATURE OF WITNESS<br>[Illegible] |  | 19. SIGNATURE OF CLERK<br>[Illegible] |  | 20. SIGNATURE OF REGISTRAR<br>[Illegible] |  |

BUREAU V. 2

APR 30 1959

RECEIVED

STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04894

|   |                                    |   |  |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Pr. Georges</b> <b>MARYLAND</b>   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>College Park</b>   |  |
| c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |                                    | d. STREET ADDRESS<br><b>5022 Lakeland Road</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Ieland Memorial Hospital</b>   |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ivy</b> Middle <b>Few</b> Last <b>Few</b>   |                                    | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>30</b> Year <b>1958</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-12-57</b>              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>*****</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>   | 9. AGE (In years last birthday)<br>yrs. <b>5</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Douglas Few</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Betty Barber</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>(Yes, no, or unknown)</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>(If yes, give war or dates of service)</b>  |  |
| 17. INFORMANT<br><b>Mrs. Betty Few; same address as # 2.</b>  |                                    | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Aspiration of food</b><br>(c) <b>Aspiration of strained peaches just fed to infant.</b><br>DUE TO<br>(c) <b>Aspiration of strained peaches just fed to infant.</b>  |                                    |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Aspiration of strained peaches just fed to infant.</b>  |                                    |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                    | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Aspiration of strained peaches just fed to infant.</b>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>3:30</b> p. m. <b>4-30-1958</b>  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br><b>Home</b>                                    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>   |                                    | 20f. (City or town) (County) (State)<br><b>College Park, Pr. Geo. Md.</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                    |   |  |
| ACTUAL SIGNATURE<br><b>John T. Maloney</b>  |                                    | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><b>John T. Maloney, M.D.</b>  |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                    | DATE SIGNED<br><b>April 30, 1958</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>5-2-58</b>  |                                    | 22b. DATE THEREOF<br><b>5-2-58</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Murkirk, Md.</b>   |                                    | 22d. LOCATION (City, town, or county) (State)<br><b>Murkirk Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. Ernest Garner</b>   |                                    | 24a. REC'D BY REGISTRAR<br><b>W. Ernest Garner</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>W. Ernest Garner</b>   |                                    | 24c. DATE<br><b>MAY 5 '58</b>   |  |

VS. A15ME  
SM 2/57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077234xVI

FOR STATE  
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |                                     |  |  |  |
|--|--|-------------------------------------|--|--|--|
| Name of Deceased<br>John T. McHenry, Jr.     |  | Sex<br>Male                         |  | Age<br>45  |  |
| Date of Death<br>April 20, 1958              |  | Place of Death<br>Home              |  | Cause of Death<br>Myocardial Infarction          |  |
| Manner of Death<br>Natural                   |  | Occupation<br>Physician             |  | Residence<br>1000 Lehigh Road, College Park, Md. |  |
| Signature of Medical Examiner<br>[Signature] |  | Signature of Coroner<br>[Signature] |  | Signature of Registrar<br>[Signature]            |  |
| Date of Certificate<br>April 22, 1958        |  | Place of Issue<br>Baltimore, Md.    |  | County<br>Anne Arundel                           |  |

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04895

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Landover Hills</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>  |                                  |   | d. STREET ADDRESS<br><b>4015 71st Avenue</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>Anthony</b> Last <b>Forame</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>25</b> Year <b>19 58</b>  |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-28-18</b>   | 9. AGE (in years last birthday)<br><b>39</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Merchant</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Awning</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>                                      |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  |   | 13. FATHER'S NAME<br><b>Salvatore Forame</b>  |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Louise Cheseldine</b>   |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |   |   |
| 16. SOCIAL SECURITY NO.<br><b>Leo Roy Forame;</b>   |                                  |   | 17. INFORMANT<br><b>1131 W. Virginia Ave., N.E. Washington, D.C.</b>  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b><br>DUE TO<br>(b) <b>Gunshot wounds of chest and abdomen</b><br>DUE TO<br>(c) <b>Gunshot wounds of chest and abdomen</b>  |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Homicide</b>   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>8:30 a.m. 4-25-58</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>automobile</b>               |   |
| 20f. (City or town)<br><b>Landover Hills, Pr. Geo. Md.</b>  |                                  | 20g. (County) (State)   |   |   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |   |   |
| ACTUAL SIGNATURE<br><b>John T. Maloney</b>  |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |   |
| EXAMINER'S NAME (Type)<br><b>John T. Maloney, M.D.</b>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                  | DATE SIGNED<br><b>April 25, 1958</b>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4-28-58</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln</b>   |   |
| 22d. LOCATION (City, town, or county)<br><b>Colmar Manor, Md.</b>   |                                  | (State)   |   |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Lee Funeral Home Washington D.C.</b>   |                                  |   | ADDRESS   |   |   |
| 24a. REC'D BY REGISTRAR<br><b>APR 28 '58</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. Beach</b>  |   |   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 28 1959

BUREAU V. S.

1111 N. Virginia Ave.,  
Washington, D.C.

My telephone number is

Living

Washington, D.C.

U.S.A.

Telephone and check

name of name of child and address

Home

My telephone number is

Living

U.S.A.

John F. Kennedy, D.C.

My telephone number is

Living

U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4874

CERTIFICATE OF DEATH

Reg. Dist. No.

04896

|  |                        |  |                                  |
|--|------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George's                     |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>College Park, Md.  |                        | c. LENGTH OF STAY IN 1b<br>14 College Park, Md.  |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>4713 Greenbelt Road,.  |                        | d. STREET ADDRESS<br>4713 Greenbelt, Road,.  |                                  |
| 3. NAME OF DECEASED (Type or print) ESTELLA First VIOLA Middle FULLER Last   |                        | 4. DATE OF DEATH April 21, 1958  |                                  |
| 5. SEX female  | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 19, 1882  |
| 9. AGE (In years last birthday) 76 yrs.  |                        | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                        | 10b. KIND OF BUSINESS OR INDUSTRY<br>own home  |                                  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland  |                        | 12. CITIZEN OF WHAT COUNTRY?<br>U S A  |                                  |
| 13. FATHER'S NAME<br>Emanuel Jenkins   |                        | 14. MOTHER'S MAIDEN NAME<br>Elizabeth Walters  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>no   |                        | 16. SOCIAL SECURITY NO.<br>none  |                                  |
| 17. INFORMANT<br>O W Fuller  |                        | Address<br>College Park, Md.   |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis.<br>DUE TO Ac congestive Heart Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) |                        |  | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                        |  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                        | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                        | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that I attended the deceased from April 21, 1958, to April 22, 1958, that I last saw the deceased alive on April 22, 1958, and that death occurred at 12 M, from the causes and on the date stated above.  |                        |  |                                  |
| ACTUAL SIGNATURE W.L. Etienne  |                        | DATE SIGNED 4/22/58  |                                  |
| PHYSICIAN'S NAME (Type) W.L. ETIENNE   |                        | ADDRESS (Street, city or town, state) 4713 Greenbelt Rd College Park, Md.  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Transportation  |                        | 22b. DATE THEREOF<br>4/23/58   |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY<br>Cumberland   |                        | 22d. LOCATION (City, town, or county) (State)<br>Maryland  |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>F. Gasch's Sons  |                        | ADDRESS<br>Hyattsville Md.   |                                  |
| 24a. REC'D BY REGISTRAR<br>DATE APR 25 1958  |                        | 24b. REGISTRAR'S SIGNATURE   |                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. S.

APR 25 1958

RECEIVED

## 4942 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |   |  |
|--|----------------------------------|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Prince George Co.</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <u>md</u> b. COUNTY <u>P.G.</u>                        |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bondswine</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bondswine md</u>   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>   |                                  | d. STREET ADDRESS <u>1</u>   |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>W.</u> Last <u>Garner</u>  |                                  | 4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1958</u>   |   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>C</u>        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 5, 1896</u>  |  |
| 9. AGE (In years last birthday) <u>61</u> yrs.   |                                  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   | IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>  |   |  |
| 11. BIRTHPLACE (State or foreign country) <u>md</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |  |
| 13. FATHER'S NAME <u>  </u>  |                                  | 14. MOTHER'S MAIDEN NAME <u>  </u>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>  |                                  | 16. SOCIAL SECURITY NO. <u>  </u>  |   |  |
| 17. INFORMANT <u>James Garner Bondswine md</u>   |                                  | Address <u>  </u>  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] (a) <u>Arteriosclerosis</u><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (b) <u>Generalized Cardiac Vascular Renal Disease</u><br><u>442X</u> DUE TO (c) <u>Aging Process</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>                                     |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |                                  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>   |                                  | 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>   |   |  |
| 21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>58</u> , to <u>4-24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>58</u> , and that death occurred at <u>6:00</u> M, from the causes and on the date stated above.   |                                  |  |   |  |
| ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.   |                                  | ADDRESS (Street, city or town, state) <u>Bondswine md</u> DATE SIGNED <u>  </u>  |   |  |
| PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>   |                                  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>4-28-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St Phillip Cem.</u>  | 22d. LOCATION (City, town, or county) (State) <u>Aquasco md</u>                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. S. Nelson 1348 N. Calhoun St</u>  |                                  | 24a. REC'D BY REGISTRAR <u>  </u> DATE <u>APR 28 '58</u>   | 24b. REGISTRAR'S SIGNATURE <u>  </u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. E.

APR 29 1958

RECEIVED  
APR 29 1958

4901

CERTIFICATE OF DEATH

04899

Reg. Dist. No.

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>P. GEORGE</u> MARYLAND  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>WASH D.C.</u> b. COUNTY <u>P.D.</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Wash D.C. 28</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Ann's General</u>   |                                 | d. STREET ADDRESS <u>1412 Boone Hill Rd S.E.</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>TONY</u> Middle <u>GEORGE</u> Last <u>GEORGE</u>   |                                 | 4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1958</u>  |  |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>N</u>       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-24-1894</u>                             |
| 9. AGE (In years last birthday) <u>63</u> yrs.  |                                 | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Bakery</u>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <u>Packer</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Russia</u>   |                                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>unknown</u>  |                                 | 14. MOTHER'S MAIDEN NAME <u>unknown</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                                 | 16. SOCIAL SECURITY NO. <u>236-07-1468</u>   |  |
| 17. INFORMANT <u>Mary Belton</u> Address <u>1405 Boone Hill Rd S.E.</u>   |                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral of CVA</u><br>163X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO<br>(c) |                                 | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL-DISEASE CONDITION GIVEN IN PART I (a)   |                                 |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>March 3, 1957</u> to <u>April 7, 1958</u> , that I last saw the deceased alive on <u>April 3, 1958</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.  |                                 |  |  |
| ACTUAL SIGNATURE <u>Director Picky</u> M.D. <u>35-264-111</u>   |                                 | ADDRESS (Street, city or town, state) <u>WASH D.C.</u> DATE SIGNED <u>4/7/58</u>   |  |
| PHYSICIAN'S NAME (Type)   |                                 |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF <u>4-9-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MT Olivet Cem.</u>   | 22d. LOCATION (City, town, or county) (State) <u>WASH D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>300-4th St N.E.</u>   |                                 | 24a. REC'D BY REGISTRAR <u>APR 10 58</u>   | 24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>                  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

|                     |  |        |  |        |  |         |  |               |  |                   |  |                  |  |                   |  |                   |  |                     |  |                            |  |                            |  |                          |  |                           |  |                              |  |                                  |  |                               |  |                           |  |                         |  |                        |  |  |  |
|---------------------|--|--------|--|--------|--|---------|--|---------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|---------------------------|--|------------------------------|--|----------------------------------|--|-------------------------------|--|---------------------------|--|-------------------------|--|------------------------|--|--|--|
| 1. NAME OF DECEASED |  | 2. SEX |  | 3. AGE |  | 4. RACE |  | 5. OCCUPATION |  | 6. PLACE OF BIRTH |  | 7. DATE OF BIRTH |  | 8. PLACE OF DEATH |  | 9. CAUSE OF DEATH |  | 10. MANNER OF DEATH |  | 11. SIGNATURE OF PHYSICIAN |  | 12. SIGNATURE OF REGISTRAR |  | 13. SIGNATURE OF WITNESS |  | 14. SIGNATURE OF DECEASED |  | 15. SIGNATURE OF NEXT OF KIN |  | 16. SIGNATURE OF BURIAL OFFICIAL |  | 17. SIGNATURE OF FUNERAL HOME |  | 18. SIGNATURE OF CEMETERY |  | 19. SIGNATURE OF CHURCH |  | 20. SIGNATURE OF OTHER |  |  |  |
|                     |  |        |  |        |  |         |  |               |  |                   |  |                  |  |                   |  |                   |  |                     |  |                            |  |                            |  |                          |  |                           |  |                              |  |                                  |  |                               |  |                           |  |                         |  |                        |  |  |  |

BUREAU V. B.

APR 10 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04898**

**4902**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Northumberland</b>        |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Heverly, Md</b>   |  |  |  | c. LENGTH OF STAY IN 1b  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Thomas</b> Middle <b>Jester</b> Last <b>George</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>3</b> Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9/11/1865</b>                                |  |
| 9. AGE (In years last birthday)<br><b>92</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days   |  | IF UNDER 24 HRS.<br>Hours Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>farmer</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  |  |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>no</b>   |  | 17. INFORMANT<br><b>James W George</b>   |  | Address<br><b>Glendale, Maryland</b>                                |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Fracture of left femur</b><br>DUE TO<br>(c)   |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell down stairs at Alms House</b>                    |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>5/17</b> 19 <b>58</b><br>p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Alms House</b>  |  | 20f. (City or town) (County) (State)<br><b>Westall P.S. Md</b>      |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>James I. Boyd</b>   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type)<br><b>JAMES I. Boyd</b>   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>4/17/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Lively - Va</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Sacks some Hyattsville Md</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br><b>DATE APR 8 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Alb. Leach</b>                     |  |

FOR STATE  
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

RECEIVED  
APR 8 1958  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4943

Reg. Dist. No. 04900

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

Prince Georges MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

District Heights

c. LENGTH OF STAY in lb

4 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

7804 Elmherst Street

## 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE New York b. COUNTY Kings

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

New York 69x-3

d. STREET ADDRESS

725-57th Street

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☐3. NAME OF  
DECEASED  
(Type or print)First Middle Last  
Charles Edward Gillin4. DATE  
OF DEATHMonth Day Year  
April 19 1958

## 5. SEX

male

## 6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

## 8. DATE OF BIRTH

April 26, 1892 66 yrs.

## 9. AGE (in years last birthday)

66 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## IF UNDER 24 HRS.

Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Adventuring

## 10b. KIND OF BUSINESS OR INDUSTRY

Retired

## 11. BIRTHPLACE (State or foreign country)

New York

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Robert Gillin

## 14. MOTHER'S MAIDEN NAME

Mary Nolan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

yes white

## 16. SOCIAL SECURITY NO.

Joseph Perez same as #1

## 17. INFORMANT

Address

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

442x

## DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

## (b)

## (c)

Acute Congestive heart failure  
Cardiovascular renal diseaseINTERVAL BETWEEN  
ONSET AND DEATH

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour a. m.  
p. m.Month, Day, Year  
1920d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

James T. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

## DATE SIGNED

April 29, 1958

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

5/2/58

## 22c. NAME OF CEMETERY OR CREMATORY

Holy Cross Cemetery

## 22d. LOCATION (City, town, or county)

Brooklyn New York

## (State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

F. Gasch's Sons Hyattsville Md.

## 24a. REC'D BY REGISTRAR

DATE MAY 5 '58

## 24b. REGISTRAR'S SIGNATURE

Allan

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH



|                     |  |                     |  |                       |  |                     |  |                      |  |
|---------------------|--|---------------------|--|-----------------------|--|---------------------|--|----------------------|--|
| NAME OF DECEASED    |  | AGE                 |  | SEX                   |  | RACE                |  | RELIGION             |  |
| DATE OF DEATH       |  | TIME OF DEATH       |  | PLACE OF DEATH        |  | CAUSE OF DEATH      |  | MANNER OF DEATH      |  |
| DISEASE OR INJURY   |  | DURATION OF ILLNESS |  | PREVIOUS ILLNESS      |  | TREATMENT           |  | HISTORY              |  |
| FINDINGS AT AUTOPSY |  | OPINION OF EXAMINER |  | SIGNATURE OF EXAMINER |  | DATE OF EXAMINATION |  | PLACE OF EXAMINATION |  |



APR 22 1958

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04902

FOR STATE  
HEALTH DEPT.

4945

|   |                                  |   |  |  |  |   |   |
|---|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Oxen Hill Maryland.</b>  |                                  | c. LENGTH OF STAY IN TB<br><b>5 years</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Oxen Hill Maryland.</b>                                   |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>7222 E Fort Foote Terrace</b>  |                                  |   |  | d. STREET ADDRESS<br><b>7222 E Fort Foote Terrace</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>June Clarice Godsey</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>April 1, 19 58-</b>   |  |   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept 9, 1922</b>  |  | 9. AGE (In years last birthday)<br><b>35</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Medical technician</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Bristol Tennessee</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |   |
| 13. FATHER'S NAME<br><b>James M Godsey</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Poore</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT<br><b>Louise Michaelis 7222 E Fort Foote Terrace Oxen Hill Maryland</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>434.1 Congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause lost. DUE TO (c)  |                                  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |                                  |   |  |  |  |   |   |
| ACTUAL SIGNATURE<br><b>James I. Boyd</b>  |                                  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
| EXAMINER'S NAME (Type)<br><b>James I. Boyd</b>  |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
|   |                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 1, 1958</b>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>   |                                  | 22b. DATE THEREOF<br><b>4/3/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>East Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Bristol, Tenn.</b>                            |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Company</b>   |                                  |   |  | ADDRESS<br><b>2901 14th St. N.W. Washington 9, D.C.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>APR 3 '58</b>   |   |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Redeuch</b>   |  |   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 7 1953

BUREAU V. 2

FOR STATE  
HEALTH DEPT



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1953

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4903

## CERTIFICATE OF DEATH

04903

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b><br>c. LENGTH OF STAY IN 1b<br><b>1 Day</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>25 Riverdale</b><br>d. STREET ADDRESS<br><b>1 4808 Rittenhouse /St</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Annie</b><br>Middle<br><b>Selina</b><br>Last<br><b>Graham</b>   |  |   |  | 4. DATE OF DEATH<br>Month<br><b>April</b><br>Day<br><b>19</b><br>Year<br><b>19 58</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>4/3/84</b>  |  |
| 9. AGE (In years lost birthday)<br><b>74</b> yrs.  |  | IF UNDER 1 YEAR<br>Months<br><b>74</b>  |  | IF UNDER 24 HRS.<br>Days<br><b>74</b>   |  | Hours<br><b>74</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>H-wife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>England</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Hannah S. Wilde</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>John C. Graham, 4808 Rittenhouse St.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b><br>DUE TO <b>Bronchopneumonia, LLL,</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic hh disease</b><br>DUE TO (c) <b>—</b>   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>491X</b>   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Mar. 16</b> , 19 <b>58</b> , to <b>Apr. 19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Apr. 19</b> , 19 <b>58</b> , and that death occurred at <b>10:50 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>3308 Perry St. Mt. Rainier, Md.</b> DATE SIGNED <b>4/20/58</b> |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>C. C. Hageage</b>  |  |   |  | PHYSICIAN'S NAME (Type) <b>Dr. C. Hageage</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>4/22/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Pr. Geo. Co., Md.</b>              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.W. Chambers Co. Inc.</b>  |  |   |  | ADDRESS<br><b>Riverdale, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 23 '58</b>                                      |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Alberich</b>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled (including page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

BUREAU Y. S.

APR 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4904 CERTIFICATE OF DEATH

Reg. Dist. No. 04904

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 Days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale 25</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General</b>  |  |   |  | d. STREET ADDRESS<br><b>4609 Rittenhouse St.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cora</b> Middle <b>Graham</b> Last <b>Graham</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>7</b> Year <b>19 58</b>   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11-29-73</b>   |  |
| 9. AGE (In years lost birthday) yrs. <b>84</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.     |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>KANSAS</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 13. FATHER'S NAME<br><b>JOHN HAMBURG</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>REBECCA</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>212-10-2632</b> |  | 17. INFORMANT<br><b>ALETA M. ROGERS</b>   |  | Address<br><b>12007 BROOKSHAVEN SILVER SPRING MD</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO<br>(c) <b>6 mos.</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                  |  |
| 20f. (City or town) (County) (State)   |  |   |  | 20g. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>APRIL 5, 1958</b> to <b>APRIL 7, 1958</b> that I last saw the deceased alive on <b>APRIL 7, 1958</b> , and that death occurred at <b>9:20 AM</b> , from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Norman Donat Comeau</b> M.D.   |  |   |  | ADDRESS (Street, city or town, state) <b>3503 PERRY ST</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>NORMAN DONAT COMEAU</b>   |  |   |  | DATE SIGNED <b>4/7/58</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |   |  | 22b. DATE THEREOF<br><b>4/9/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ST. PETERS CEMETERY BALTIMORE, MD.</b>                         |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MD.</b>   |  |   |  | 22e. REC'D BY REGISTRAR<br><b>APR 10 '58</b>  |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. H. Chambers &amp; Co.</b>  |  |   |  | 24. REGISTRAR'S SIGNATURE<br><b>W. H. Chambers</b>  |  |   |  |

CERTIFICATE OF DEATH

CLAIM BOND

BUREAU V. E.

APR 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04905

## 4946 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                 |   |   |   |   |  |  |
|---|---------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGES</u> MARYLAND   |                                 |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BERKSHIRE</u>  |                                 | c. LENGTH OF STAY IN 1b<br><u>21 YRS</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X BERKSHIRE</u>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>7613 Walter Lane</u>   |                                 |   |   | d. STREET ADDRESS<br><u>7613 WALTERS LANE</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>JAMES EDWARD GREEN, SR</u>   |                                 |   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>APRIL 7 1958</u>   |   |  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Can.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 16, 1879</u> | 9. AGE (In years lost birthday) yrs.<br><u>78</u>   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Painter</u>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Government</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Washington, D.C.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  |
| 13. FATHER'S NAME<br><u>James E. Green</u>  |                                 |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Waters</u>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |                                 | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><u>unknown</u>  |   | 17. INFORMANT<br>Name <u>Mrs. Grace E. Green</u> Address <u>7613 Walter Lane, Berkshires, Md.</u>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Congestive myocarditis</u><br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Arteriosclerotic myocarditis</u><br>DUE TO (c) <u>General Arteriosclerosis</u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>unknown</u><br><u>unknown</u> |                                 |   |   |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Chronic Bronchitis for past 2 years</u>   |                                 |   |   |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Natural Causes</u>                                       |   |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. ft. p. m.<br><u>19</u>   |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>April 1, 1957</u> to <u>April 7, 1958</u> , that I last saw the deceased alive on <u>April 7, 1958</u> , and that death occurred at <u>11:40</u> M., from the causes and on the date stated above.   |                                 |   |   |   |   |  |  |
| ACTUAL SIGNATURE<br><u>Paulo Vannatta</u>   |                                 |   |   | ADDRESS (Street, city or town, state)<br><u>5440 Silver Hill Rd SE Washington 28 DC</u>   |   |  |  |
| PHYSICIAN'S NAME (Type)<br><u>PAULO VAN NATTA</u>   |                                 |   |   | DATE SIGNED<br><u>APR 10 '58</u>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                 | 22b. DATE THEREOF<br><u>4-10-58</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Not. Orlinet Corn.</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Washington, D.C.</u>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W.W. Chambers Co Washington, D.C.</u>  |                                 |   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 10 '58</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>W. W. Chambers</u>  |  |

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RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4905

FOR STATE  
HEALTH DEPT.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chesverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Frank Roberts Hackl</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>27</b> Year <b>19 58</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>December 3, 02</b> |
| 9. AGE (In years last birthday)<br><b>55</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Police</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Frank J. Hackl</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Suzanna Roberts</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>(Yes, no, or unknown)</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Grace Hackl; Same address as #2.</b>   |   |
| 17. INFORMANT<br><b>Grace Hackl; Same address as #2.</b>  |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Toxemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Sodium Cyanide Poisoning</b><br>DUE TO<br>(c) <b>Consumed a quantity of cyanide solution</b> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Consumed a quantity of cyanide solution</b>   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m.<br><b>4-27-58</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>   |                                  | 20f. (City or town) (County) (State)<br><b>Hyattsville, Pr. Geo. Md.</b>   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |  |   |
| ACTUAL SIGNATURE<br><b>John T. Maloney</b>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>John T. Maloney, M.D.</b>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4/30/58</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greenup</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hyattsville, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Basche</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>APR 29 1958</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>W. J. [Signature]</b>  |                                  |  |   |

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STAMP  
HEALTH DEPT

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, date of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

APR 29 1958

RECEIVED

## 4906 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>p. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jessup</b> ✓ |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General</b>  |  |   |  | d. STREET ADDRESS<br><b>229 Mission Rd.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First<br><b>Rebecca</b><br>Middle<br><b>L</b><br>Last<br><b>Hager</b>   |  | 4. DATE OF DEATH<br>Month<br><b>April</b><br>Day<br><b>5</b><br>Year<br><b>1958</b>                       |  | 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>10-12-57</b>   |  | 9. AGE (In years last birthday)<br>yrs. <b>5</b> Months <b>5</b> Days <b>24</b>   |  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>24</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Father Thomas C. Hager</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Phyllis O. Pennington</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>340.3</b> DUE TO <b>Diffuse Purulent Meningitis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>4-4-58</b> , to <b>4-5-58</b> , that I last saw the deceased alive on <b>4-5-58</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>John W. Perkins</b>  |  |   |  | DATE SIGNED<br><b>5301 Hamilton St., Hyattsville Md 4/5/58</b>  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. John W. Perkins</b>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>April 7, 1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cabrera Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cabrera West Virginia</b>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>De Witt Canadon</b>  |  | ADDRESS<br><b>Laurel Md</b>   |  | 24a. REC'D BY REGISTRAR<br><b>APR 9 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. Beach</b>   |  |

2036 275XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. B.

APR 9 1958

RECEIVED

4947

## CERTIFICATE OF DEATH

Reg. Dist. No. 04908

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGES</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>56 SILVER SPRING</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | d. STREET ADDRESS<br><b>18108 TAHONA DRIVE</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>IDA</b> Middle <b>FLAX</b> Last <b>HAYS</b>   |   | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>14</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/19/1892</b>   |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA - Md.-Balto.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>LOUIS FLAX</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>MARY PAULSON</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>HARRY HAYS</b>  |   | Address<br><b>SILVER SPRING, Md</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0 CORONARY THROMBOSIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 HOURS</b>   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>260X DIABETES MELLITUS</b>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>JAN 1</b> , 19 <b>53</b> , to <b>APR 14</b> , 19 <b>58</b> , that I lost saw the deceased alive on <b>APR 14</b> , 19 <b>58</b> , and that death occurred at <b>3 A. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>4300 KAY WOOD DRIVE APR 14 '58</b><br>ACTUAL SIGNATURE <b>Samuel J N Sugar</b> M.D. <b>MT RAINIER, Md.</b><br>PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b> |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 22b. DATE THEREOF<br><b>APRIL-15-1958</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ADAS ISRAEL CEMETERY</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>WASHINGTON D.C.</b>                           |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>BERNARD DANZANSKY</b>  |   | 24a. REC'D BY REGISTRAR<br><b>4505-3501-14th St. N.W.</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>APR 16 '58</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4948

## CERTIFICATE OF DEATH

Reg. Dist. No.

04903

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges'</b>          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL-Ritchie</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>20 years</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>6326 Ritchie Road, S.E.</b>  |  |   |  | d. STREET ADDRESS<br><b>6326 Ritchie Road, S.E.</b>   |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Anna</b> Middle <b>Bell</b> Last <b>Ham</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>28</b> , Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan. 8, 1884</b>                                       |  |
| 9. AGE (In years last birthday)<br><b>74 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Postmistress</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Government</b>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Texas</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>David McLaughlin</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Della Means</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>---</b>   |  | 17. INFORMANT<br><b>Mrs. Mignon Hester-same as above.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>450.0</b><br><b>450.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Acute Congestive Cardiac failure</b><br>(c) <b>General Arteriosclerosis</b>                       |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>3 days</b><br><b>unknown</b>                     |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>491X</b><br><b>none of note</b>   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month. Day. Year<br>Hour a. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>March 31, 1958</b> to <b>April 27, 1958</b> , that I last saw the deceased alive on <b>April 27, 1958</b> , and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>5440 Silver Hill Road, S.E., Washington 27, D. C.</b> DATE SIGNED <b>4/28/58</b> |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Paul C. Van Natta, M.D.</b> M.D. <b>5440 Silver Hill Road, S.E., Washington 27, D. C.</b>   |  |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Paul C. Van Natta, M.D.</b>  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>5/1/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Epiphany Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Forestville, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAY 6 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Reese</b>                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1948

Age and Sex

|  |  |  |  |  |  |                                       |  |
|--|--|--|--|--|--|---------------------------------------|--|
| NAME OF DECEASED<br>JAMES H. HARRIS      |  | DATE OF BIRTH<br>JAN 15 1900               |  | AGE<br>48                                  |  | SEX<br>M                              |  |
| PLACE OF BIRTH<br>BALTIMORE, MD          |  | DATE OF DEATH<br>JAN 20 1948               |  | TIME OF DEATH<br>10:30 AM                  |  | PLACE OF DEATH<br>HOME                |  |
| OCCUPATION<br>LABORER                    |  | CAUSE OF DEATH<br>HEART DISEASE            |  | MANNER OF DEATH<br>NATURAL                 |  | MEDICAL ATTENDANT<br>DR. J. H. HARRIS |  |
| EDUCATION<br>HIGH SCHOOL                 |  | RELIGION<br>METHODIST                      |  | MARITAL STATUS<br>MARRIED                  |  | SPOUSE'S NAME<br>MARY H. HARRIS       |  |
| PREVIOUS ILLNESS<br>NONE                 |  | HISTORY OF PRESENT ILLNESS<br>Sudden death |  | POST-MORTEM EXAMINATION<br>NONE            |  | CORONER'S OFFICE<br>BALTIMORE         |  |
| FAMILY HISTORY<br>NONE                   |  | SOCIAL HISTORY<br>NONE                     |  | HABITS<br>NONE                             |  | TREATMENT<br>NONE                     |  |
| SIGNATURE OF DECEASED<br>JAMES H. HARRIS |  | SIGNATURE OF WITNESS<br>J. H. HARRIS       |  | SIGNATURE OF PHYSICIAN<br>DR. J. H. HARRIS |  | SIGNATURE OF CORONER<br>J. H. HARRIS  |  |
| DATE<br>JAN 20 1948                      |  | PLACE<br>BALTIMORE, MD                     |  | COUNTY<br>BALTIMORE                        |  | STATE<br>MARYLAND                     |  |

4907 CERTIFICATE OF DEATH

Reg. Dist. No. 04910

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission)<br>a. STATE <u>Riverdale, Maryland</u> b. COUNTY <u>Prince Georges</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Riverdale</u>  |  | c. LENGTH OF STAY IN 1b<br><u>36 hours</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Leland Memorial Hospital</u>   |  | d. STREET ADDRESS<br><u>6110 Somerset Ave.</u>  |  |
| 3. NAME OF DECEASED (Type or print) (Baby Girl)<br><u>(Baby Girl)</u>   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>12</u> Year <u>19 58</u>  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>white</u>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 | 8. DATE OF BIRTH<br><u>April 10, 1958</u>                                |
| 9. AGE (In years last birthday) yrs.<br><u>25</u>   |  | 10. IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>9</u> Hours <u>50</u> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Wayne N. Holcombe</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Florence V. Smith</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><u>Mother's Hospital Chart</u>   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>atelectasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>prematurity</u><br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>1 day</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>April 10, 1958</u> to <u>April 12, 1958</u> , that I last saw the deceased alive on <u>April 11, 1958</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above.  |  |   |  |
| ACTUAL SIGNATURE<br><u>L. W. Malin</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u> DATE SIGNED <u>4-12-58</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>L. W. Malin, M.D.</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>Apr 14, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Evergreen Cemetery</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Bladensburg, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>F. Gasch's Sons</u> ADDRESS<br><u>Hyattsville Md.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 14 '58</u> 24b. REGISTRAR'S SIGNATURE<br><u>W. Redick</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2076335 XVI

APR 14 '58

Alb. Smith

40-2 CERTIFICATE OF DEATH

|                       |  |                                |  |                        |  |
|-----------------------|--|--------------------------------|--|------------------------|--|
| NAME OF DECEASED      |  | DATE OF BIRTH                  |  | PLACE OF BIRTH         |  |
| JAMES HENRY HARRIS    |  | JAN 1 1901                     |  | BALTIMORE, MD          |  |
| MARRIAGE              |  | DATE OF MARRIAGE               |  | PLACE OF MARRIAGE      |  |
| MARRIED               |  | JUN 15 1925                    |  | BALTIMORE, MD          |  |
| OCCUPATION            |  | DATE OF DEATH                  |  | PLACE OF DEATH         |  |
| LABORER               |  | APR 14 1958                    |  | BALTIMORE, MD          |  |
| CAUSE OF DEATH        |  | MANNER OF DEATH                |  | MEDICAL ATTENDANT      |  |
| HEART DISEASE         |  | NATURAL                        |  | DR. J. H. HARRIS       |  |
| DETAILS OF DEATH      |  | DATE OF INTERMENT              |  | PLACE OF INTERMENT     |  |
| DECEASED DIED AT HOME |  | APR 14 1958                    |  | BALTIMORE, MD          |  |
| SIGNATURE OF DECEASED |  | SIGNATURE OF MEDICAL ATTENDANT |  | SIGNATURE OF REGISTRAR |  |
| JAMES HENRY HARRIS    |  | DR. J. H. HARRIS               |  | J. H. HARRIS           |  |
| DATE OF SIGNATURE     |  | DATE OF SIGNATURE              |  | DATE OF SIGNATURE      |  |
| APR 14 1958           |  | APR 14 1958                    |  | APR 14 1958            |  |

BUREAU V. S.

APR 14 1958

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04911

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

## 1. PLACE OF DEATH

a. COUNTY

Prince Georges MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Allentown

c. LENGTH OF STAY IN 1b

5 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

6278 Allentown Rd

## 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

a. STATE

Maryland

b. COUNTY

Prince Georges

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Allentown

d. STREET ADDRESS

6278 Allentown Rd

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

## 3. NAME OF DECEASED (Type or print)

Cecil

First

Harrison

Middle

Holsinger

Last

## 4. DATE OF DEATH

April

Month

12

Day

1958

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

## 8. DATE OF BIRTH

March 31, 1906

## 9. AGE (In years last birthday)

52 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## IF UNDER 24 HRS.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Builder

## 10b. KIND OF BUSINESS OR INDUSTRY

Real Estate

## 11. BIRTHPLACE (State or foreign country)

Virginia

## 12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME

Russell

Holsinger

## 14. MOTHER'S MAIDEN NAME

Lulu Ann Connor

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

Yes

## 16. SOCIAL SECURITY NO.

577-03-68

## 17. INFORMANT

Mrs. Ruth E. Holsinger

## Address

same as #2

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

976X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Hemorrhage and shock

Gun shot wound of abdomen

## INTERVAL BETWEEN ONSET AND DEATH

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

## 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Shot self in epigastrium with 12 gauge shotgun

## 20c. TIME OF INJURY

5:10 a.m.

## Month, Day, Year

April 12, 1958

## 20d. INJURY OCCURRED

While of work ☐ Not while of work ☐

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Yard of home

## 20f. (City or town)

Allentown

## (County)

P. G.

## (State)

Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

## ACTUAL SIGNATURE

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

## DATE SIGNED

April 12, 1958

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial April 16, 58

## 22b. DATE THEREOF

April 16, 58

## 22c. NAME OF CEMETERY OR CREMATORY

Allentown National Arlington

## 22d. LOCATION (City, town, or county)

Va

## (State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Simmans Bros

## ADDRESS

1661 - good Hope Rd

## 24a. REC'D BY REGISTRAR

APR 14 58

## DATE

## 24b. REGISTRAR'S SIGNATURE

[Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH OFFICE

BUREAU V. 2

APR 14 1968

RECEIVED

## 4908 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <del>Anne Arundel</del> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>4 Hrs 15 Min</b> <del>X</del> <b>Kendleworth,</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>4616 R Street</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>John</b> Middle <b>G</b> Last <b>Hornig</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>13</b> Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/14/79</b> <b>3-14-77</b> <del>81</del>                                   |  |
| 9. AGE (In years last birthday) yrs.<br><b>77</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dispatcher</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Capital Transit</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>                              |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Roman Hornig</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Cornwell</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br>(If yes, give year or dates of service)<br><b>578-10-77430</b> |  | 17. INFORMANT<br>Address<br><b>Louise Hornig 4616 R St. Kendleworth, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Infarction, Int. Capsule</b><br>DUE TO<br>(c) <b>H.C.V.D.</b> |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>4/13</b> , 19 <b>58</b> , to <b>4/13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/13</b> , 19 <b>58</b> , and that death occurred at <b>9:58 P.M.</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>C. Louis Mendel</b> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <b>4506 Callege Ave</b> DATE SIGNED <b>4/14/58</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>C. LOUIS MENDEL</b>  |  |   |  | <b>Callege Park Ind</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>4-17-58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Lincolns Cem.</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Bladensburg Maryland</b>                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.W. Chambers Co. 517-11th Street D.C.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 17 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. K. Kouch</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| NAME OF DECEASED<br>[Faint text, possibly "John Doe"]     |  | SEX<br>[Faint text, possibly "Male"]                   |  | AGE<br>[Faint text, possibly "45"]                 |  | RACE<br>[Faint text, possibly "White"]                 |  |
| PLACE OF BIRTH<br>[Faint text, possibly "Baltimore, Md."] |  | DATE OF BIRTH<br>[Faint text, possibly "Jan 15, 1910"] |  | TIME OF DEATH<br>[Faint text, possibly "10:30 AM"] |  | DATE OF DEATH<br>[Faint text, possibly "Apr 12, 1958"] |  |
| CAUSE OF DEATH<br>[Faint text, possibly "Heart Disease"]  |  | MANNER OF DEATH<br>[Faint text, possibly "Natural"]    |  | PLACE OF DEATH<br>[Faint text, possibly "Home"]    |  | TIME OF DEATH<br>[Faint text, possibly "10:30 AM"]     |  |
| SIGNATURE OF PHYSICIAN<br>[Faint signature]               |  | SIGNATURE OF CORONER<br>[Faint signature]              |  | SIGNATURE OF DECEASED<br>[Faint signature]         |  | SIGNATURE OF WITNESS<br>[Faint signature]              |  |
| CERTIFICATE OF DEATH<br>[Faint text]                      |  | CERTIFICATE OF DEATH<br>[Faint text]                   |  | CERTIFICATE OF DEATH<br>[Faint text]               |  | CERTIFICATE OF DEATH<br>[Faint text]                   |  |

BUREAU V. S.

APR 17 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4950

Reg. Dist. No. 04913

FOR STATE HEALTH DEPT.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b> Md.</b> b. COUNTY <b>Prince Georges</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Arden</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>8 years</b>   |  |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Arden</b>  |  |   |  | d. STREET ADDRESS<br><b>3rd and Lincoln Avenue</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>3rd and Lincoln Avenue</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Jones</b> Last <b>Jones</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>6</b> Year <b>1958</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Col.</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3-15-1990</b>                                  |  |
| 9. AGE (In years last birthday)<br><b>68</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>19</b>   |  | IF UNDER 24 HRS.<br>Hours <b>58</b> Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Contractor</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Trash Collection</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Robert Milton Jones</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Bradley</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><b>225-05-3083</b>                   |  | 17. INFORMANT<br>Address <b>Alberta Jones; same address as # 2.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Cardiovascular renal disease</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>4/10/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Memorial Ceme.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Wuitland, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John S. Lewis</b>   |  |   |  | ADDRESS<br><b>30 H Street, N.E.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 8 '58</b>                      |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Alberta Jones</b>  |  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

21

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| Name of Deceased<br>John A. Jones                  |  | Age<br>8 years   |  |
| Sex<br>Male  |  | Race<br>White  |  |
| Date of Death<br>April 8, 1938                     |  | Place of Death<br>Home, 1234 Main Avenue, Baltimore, Md. |  |
| Cause of Death<br>Sudden                           |  | Manner of Death<br>Natural                               |  |
| Signature of Medical Examiner<br>J. A. Jones, M.D. |  | Signature of Coroner<br>J. A. Jones, M.D.                |  |
| Date of Report<br>April 10, 1938                   |  | Time of Report<br>10:00 A.M.                             |  |

RECEIVED  
APR 8 1938  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4951 CERTIFICATE OF DEATH

04914

Reg. Dist. No.

|   |                               |  |                                  |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>         |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>   |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1513-59th Ave.</u>  |                               | d. STREET ADDRESS <u>1513-59th Ave.</u>  |                                  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>ROBERT WILLIAM JONES</u>  |                               | 4. DATE OF DEATH Month Day Year<br><u>4-29-1958</u>  |                                  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-30-57</u> |
| 9. AGE (In years last birthday) yrs. <u>4</u>   |                               | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |                                  |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                  |
| 13. FATHER'S NAME <u>Donald William Jones</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Anna Mae Graham</u>  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |                                  |
| 17. INFORMANT <u>Anna Mae Jones</u>   |                               | Address <u>1513-59th Ave Hillside Md.</u>  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>INTERSTITIAL PNEUMONIA</u><br><u>492X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(VIRAL)</u><br>DUE TO (c) |                               | INTERVAL BETWEEN ONSET AND DEATH <u>17-18 hrs.</u>   |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mild Bronchitis (Bacterial)</u>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that I attended the deceased from <u>1/1</u> , 19 <u>58</u> , to <u>4/29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/28</u> , 19 <u>58</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.  |                               |  |                                  |
| ADDRESS (Street, city or town, state) <u>4405 Bowen Road, S.E., D.C.</u> DATE SIGNED  |                               |  |                                  |
| ACTUAL SIGNATURE <u>Thomas F. Cullen</u> M.D.   |                               |  |                                  |
| PHYSICIAN'S NAME (Type) <u>THOMAS F. CULLEN</u> <u>4405-Bowen Rd. S.E. D.C.</u>   |                               |  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>5-1-58</u>  |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Blacksburg Md.</u>  |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>   |                               | ADDRESS <u>517-11th St. S.E.</u>   |                                  |
| 24a. REC'D BY REGISTRAR <u>MAY 5 '58</u>  |                               | 24b. REGISTRAR'S SIGNATURE <u>W.D. Beach</u>   |                                  |

9VVVVVVVVXVV

CERTIFICATE OF DEATH

|                            |  |                            |  |                          |  |                           |  |                              |  |
|----------------------------|--|----------------------------|--|--------------------------|--|---------------------------|--|------------------------------|--|
| 1. NAME OF DECEASED        |  | 2. SEX                     |  | 3. AGE                   |  | 4. DATE OF BIRTH          |  | 5. PLACE OF BIRTH            |  |
| JAMES H. SMITH             |  | Male                       |  | 45                       |  | Jan 15, 1900              |  | Baltimore, Md.               |  |
| 6. OCCUPATION              |  | 7. CAUSE OF DEATH          |  | 8. MANNER OF DEATH       |  | 9. PLACE OF DEATH         |  | 10. DATE OF DEATH            |  |
| Clerk                      |  | Myocardial Infarction      |  | Natural                  |  | Home                      |  | Jan 20, 1945                 |  |
| 11. SIGNATURE OF PHYSICIAN |  | 12. SIGNATURE OF REGISTRAR |  | 13. SIGNATURE OF WITNESS |  | 14. SIGNATURE OF DECEASED |  | 15. SIGNATURE OF NEXT OF KIN |  |
| [Signature]                |  | [Signature]                |  | [Signature]              |  | [Signature]               |  | [Signature]                  |  |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO BE FILLED BY THE REGISTRAR

TO BE FILLED BY THE PHYSICIAN

TO BE FILLED BY THE WITNESS

TO BE FILLED BY THE DECEASED

TO BE FILLED BY THE NEXT OF KIN

# 4909 CERTIFICATE OF DEATH

Reg. Dist. No.

04915

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>31 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Adelbert</b> Middle <b>F.</b> Last <b>Lansdale</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>4-</b> Day <b>6-</b> Year <b>1958</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 15th 1903</b>                       |  |
| 9. AGE (In years last birthday)<br><b>54</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Merchant</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Wash. Rubber Co.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Buffalo N.Y.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Howard S Lansdale,</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Emma W. Lansdale</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>(If yes, give war or dates of service)</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>(If yes, give war or dates of service)</b>  |  |  |  |
| 17. INFORMANT<br><b>Marion W. Lansdale</b>  |  |   |  | Address<br><b>5902 85th Ave. Hyattsville, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia Rt Lm</b><br><b>162.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Broncho genic Carcinoma Right</b> DUE TO<br>(c) <b></b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>   |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>58</b> , to <b>Apr 6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Apr 6</b> , 19 <b>58</b> , and that death occurred at <b>6:00 a.m.</b> from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Samuel J. N. Sugar</b> M.D.   |  |   |  | ADDRESS (Street, city or town, state) <b>4300 KAYWOOD DR. 4/6/58</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b>   |  |   |  | DATE SIGNED <b>Mr Rainier, 2nd</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>4-9-58</b>  |  |   |  | 22b. DATE THEREOF   |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cem</b>   |  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington D.C.</b>   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Limothy Nelson-3831-GA Ave NW</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>DATE Apr 9 '58</b>  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Alb. Smith</b>   |  |   |  |   |  |  |  |

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 13

BUREAU V. S.

APR 9 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4910 CERTIFICATE OF DEATH

Reg. Dist. No. 04916

|   |                           |  |   |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY Prince George MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Md b. COUNTY Prince George                             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last Pallie Marcus Lee   |                           | 4. DATE OF DEATH Month Day Year April 18 19 58   |   |
| 5. SEX Female   | 6. COLOR OF SKIN white    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-1-97   |
| 9. AGE (In years last birthday) 60 yrs.   |                           | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |                           | 10b. KIND OF BUSINESS OR INDUSTRY At Home  |   |
| 11. BIRTHPLACE (State or foreign country) Kentucky  |                           | 12. CITIZEN OF WHAT COUNTRY? U.S.A./   |   |
| 13. FATHER'S NAME Lott Anderson   |                           | 14. MOTHER'S MAIDEN NAME Rebbecca ( unknown)   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO   |                           | 16. SOCIAL SECURITY NO. ****   |   |
| 17. INFORMANT 9332 Defense Hy. Mr. Russell Lee Lanham, Maryland   |                           |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) 332x Cerebellar hemorrhage and thrombosis<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis of anterior cerebellar artery<br>DUE TO<br>(c) Cerebral Arteriosclerosis<br>years |                           |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                           |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>                          |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:30P M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |                           |  |   |
| ACTUAL SIGNATURE Albert Roth M.D.   |                           | 5510 Madison Street Riverdale Maryland   |   |
| PHYSICIAN'S NAME (Type) Dr. Albert Roth   |                           |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  | 22b. DATE THEREOF 4/22/58 | 22c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery   | 22d. LOCATION (City, town, or county) (State) Charleston, W. Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc. Riverdale, Md.  |                           | 24a. REC'D BY REGISTRAR DATE APR 21 '58  | 24b. REGISTRAR'S SIGNATURE  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. E.

APR 21 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4952

CERTIFICATE OF DEATH

Reg. Dist. No.

04917

|   |                                    |   |                                   |   |   |  |   |
|---|------------------------------------|---|-----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>  |                                    |   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>GLENN DALE</b>   |                                    |   |                                   | c. LENGTH OF STAY IN 1b<br><b>9 MONTHS</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D. C.</b> <b>47X-3</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>GLENN DALE HOSPITAL</b>  |                                    |   |                                   | d. STREET ADDRESS<br><b>715 F. ST., N. E.</b>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIE</b> Middle <b>LEE</b> Last <b>LEE</b>  |                                    |   |                                   | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>18</b> Year <b>19 58</b>  |   |  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>CHINESE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/7/02</b> |   | 9. AGE (In years last birthday)<br><b>55</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LAUNDRY WORKER</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>LAUNDRY</b>   |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>TOYSUNG, CHINA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |   |
| 13. FATHER'S NAME<br><b>SHUNG LEE</b>   |                                    |   |                                   | 14. MOTHER'S MAIDEN NAME<br><b>ENG SHEE</b>   |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]<br><b>NO</b>  |                                    | 16. SOCIAL SECURITY NO.<br><b>-</b>   |                                   | 17. INFORMANT<br><b>DECEASED</b> Address  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br><b>162.1</b> IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                    |                                    |   |                                   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 YEAR</b>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    |   |                                   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
| 20f. (City or town)   |                                    | 20g. (County)   |                                   | 20h. (State)  |   |  |   |
| 21. I certify that I attended the deceased from <b>7/3/57</b> , 19____, to <b>4/18/58</b> , 19____, that I last saw the deceased alive on <b>4/13/58</b> , 19____, and that death occurred at <b>11:30 PM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>GLENN DALE HOSPITAL</b> DATE SIGNED <b>4/18/58</b><br>ACTUAL SIGNATURE <b>W. Lee</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>MOE WEISS</b> <b>GLENN DALE, MARYLAND</b> |                                    |   |                                   |   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                    | 22b. DATE THEREOF<br><b>4-22-58</b>   |                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>George Wash. Cem.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>9500 Riggs Rd. Hyattsville, Md.</b>                                |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm Lee &amp; Sons</b>  |                                    |   |                                   | ADDRESS<br><b>300 H. St N.E.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>W. Lee</b> 24b. REGISTRAR'S SIGNATURE<br><b>W. Lee</b>                                   |   |

CERTIFICATE OF DEATH

|                        |  |                      |  |                      |  |                      |  |                      |  |                      |  |
|------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED       |  | AGE                  |  | SEX                  |  | RACE                 |  | DATE OF BIRTH        |  | PLACE OF BIRTH       |  |
| JAMES EARL RAY         |  | 35                   |  | Male                 |  | White                |  | 1928                 |  | Memphis, Tennessee   |  |
| MANNER OF DEATH        |  | CAUSE OF DEATH       |  | IMMEDIATE CAUSE      |  | UNDERLYING CAUSE     |  | MANNER OF DEATH      |  | CAUSE OF DEATH       |  |
| Suicide                |  | Shot                 |  | Shot                 |  | Shot                 |  | Suicide              |  | Shot                 |  |
| PLACE OF DEATH         |  | DATE OF DEATH        |  | TIME OF DEATH        |  | HOUR OF DEATH        |  | MINUTE OF DEATH      |  | SECOND OF DEATH      |  |
| St. Louis, Missouri    |  | April 4, 1968        |  | 2:01 PM              |  | 2:01 PM              |  | 00                   |  | 00                   |  |
| OCCUPATION             |  | EDUCATION            |  | RELIGION             |  | MARRIAGE             |  | SINGLE               |  | MARRIED              |  |
| Actor                  |  | High School          |  | Catholic             |  | Single               |  | Single               |  | Single               |  |
| PREVIOUS ILLNESS       |  | PREVIOUS SURGERY     |  | PREVIOUS TRAUMA      |  | PREVIOUS DRUGS       |  | PREVIOUS ALCOHOL     |  | PREVIOUS TOBACCO     |  |
| None                   |  | None                 |  | None                 |  | None                 |  | None                 |  | None                 |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF CORONER |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  |
| [Signature]            |  | [Signature]          |  | [Signature]          |  | [Signature]          |  | [Signature]          |  | [Signature]          |  |

BUREAU V. 3

APR 22 1968

RECEIVED

CERTIFICATE OF DEATH

04919

Reg. Dist. No.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGES</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLLEGE PARK</u>   |   | c. LENGTH OF STAY IN 1b <u>14 MONTHS</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |   | d. STREET ADDRESS <u>9303 - 48<sup>th</sup> PLACE</u>  |   |
| 3. NAME OF DECEASED (Type or print) <u>LOCHIE RANKIN LINKOUS</u>   |   | 4. DATE OF DEATH <u>APRIL 17 1958</u>  |   |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>WHITE</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/24/1883</u>   |
| 9. AGE (In years last birthday) <u>74</u> yrs.   |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |   |
| 13. FATHER'S NAME <u>JOSEPH PRICE LINKOUS</u>  |   | 14. MOTHER'S MAIDEN NAME <u>MARTHA FRANCES ARMENTROUT</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <u>J. FRANCES ALLEN</u> Address <u>9303 - 48<sup>th</sup> PLACE COLLEGE PARK MD</u>  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u><br><u>331X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.<br>(b) <u>ADVANCED ARTERIOSCLEROSIS</u><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>23 MONTHS</u><br><u>YEARS</u>           |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. p. m. 19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>2/4</u> , 19 <u>57</u> , to <u>4/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>58</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.   |   |  |   |
| ACTUAL SIGNATURE <u>C. Louis Mender</u> M.D.   |   | DATE SIGNED <u>4-17-58</u>   |   |
| PHYSICIAN'S NAME (Type) <u>C. LOUIS MENDER</u>   |   | <u>COLLEGE PARK MD</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>   | 22b. DATE THEREOF <u>4-18-58</u>  | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)<br><u>Christiansburg, Va?</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Lee Funeral Home. Washington, D.C.</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 21 '58</u>  | 24b. REGISTRAR'S SIGNATURE<br><u>Albert</u>                                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                  |  |                     |  |                     |  |
|------------------|--|---------------------|--|---------------------|--|
| DATE OF DEATH    |  | PLACE OF DEATH      |  | MANNER OF DEATH     |  |
| APR 21 1958      |  | BALTIMORE, MARYLAND |  | NATURAL             |  |
| AGE              |  | SEX                 |  | RACE                |  |
| 65               |  | M                   |  | W                   |  |
| BIRTH DATE       |  | BIRTH PLACE         |  | EDUCATION           |  |
| JAN 15 1893      |  | BALTIMORE, MARYLAND |  | HIGH SCHOOL         |  |
| OCCUPATION       |  | CAUSE OF DEATH      |  | IMMEDIATE CAUSE     |  |
| RETIRED          |  | CORONARY THROMBOSIS |  | CORONARY THROMBOSIS |  |
| PREVIOUS ILLNESS |  | SYMPTOMS            |  | TREATMENT           |  |
| NONE             |  | PAIN IN CHEST       |  | NONE                |  |
| HISTORY          |  | FAMILY HISTORY      |  | SOCIAL HISTORY      |  |
| NONE             |  | NONE                |  | NONE                |  |
| SIGNATURE        |  | DATE                |  | PLACE               |  |
| J. D. JONES      |  | APR 21 1958         |  | BALTIMORE, MARYLAND |  |

BUREAU V. S.

APR 21 1958

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 7, 11, 13 & 14, Film G227, 4/11/58 fcy  
4911  
CERTIFICATE OF DEATH

04920

Reg. Dist. No.

|   |                           |   |                  |
|---|---------------------------|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Md b. COUNTY Pg.  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Cheverly, Md  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>34 Brentwood, Md.   |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>Prince George General Hospital  |                           | d. STREET ADDRESS<br>3918 Allison St.   |                  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                           |   |                  |
| 3. NAME OF DECEASED (Type or print)<br>First Emma Middle Lofty Last   |                           | 4. DATE OF DEATH<br>Month April Day 3 Year 19 58  |                  |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH |
| 9. AGE (In years last birthday)<br>74 yrs.  |                           | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |                  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                  |
| 13. FATHER'S NAME<br>Louis Dyce   |                           | 14. MOTHER'S MAIDEN NAME<br>--- Hawkins   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)  |                           | 16. SOCIAL SECURITY NO.<br>none   |                  |
| 17. INFORMANT<br>Address  |                           |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 332x DUE TO Bronchopneumonia<br>(b) Cerebral Thrombosis<br>(c) Cerebral arteriosclerosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO |                           | INTERVAL BETWEEN ONSET AND DEATH<br>48 hrs<br>6 days<br>4 years   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>491x   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I attended the deceased from April 1, 1958, to April 3, 1958, that I last saw the deceased alive on April 3, 1958, and that death occurred at 9:55 A.M. from the causes and on the date stated above.  |                           |   |                  |
| ACTUAL SIGNATURE<br>Norman Donat Comeau M.D.  |                           | ADDRESS (Street, city or town, state)<br>3503 PERRY ST MT PAINIER MD  |                  |
| DATE SIGNED<br>4/3/58   |                           |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial   |                           | 22b. DATE THEREOF<br>4.7.58   |                  |
| 22c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |                           | 22d. LOCATION (City, town, or county) (State)<br>Washington, D. C.  |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Robert D. McGehee   |                           | 24a. REC'D BY REGISTRAR<br>DATE APR 7 '58   |                  |
| 24b. REGISTRAR'S SIGNATURE<br>C. E. McGehee   |                           |   |                  |

CERTIFICATE OF DEATH

1911



BUREAU V. 3

APR 7 1938

RECEIVED

4953

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b>       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>GLASS MANOR</b>  |                               | c. LENGTH OF STAY IN 1b  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <b>ELIZABETH MARIE LOMBARDY</b>   |                               | 4. DATE OF DEATH <b>April 22 1958</b>  |   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Sept. 28 - 1888</b> |
| 9. AGE (In years last birthday) <b>69</b> yrs.  |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, DC</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |   |
| 13. FATHER'S NAME <b>John E. ALLEIDER</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Josephine HEXNER</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                               | 16. SOCIAL SECURITY NO. <b>567-16-9621</b>   |   |
| 17. INFORMANT <b>Miss CAMILLE LOMBARDY</b>  |                               | Address <b>229 HAMPTON GLASS MANOR MD</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>malnutrition</b><br>DUE TO <b>174X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.<br>(b) <b>Carcinoma of the womb.</b><br>DUE TO<br>(c) |                               | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>August 20 1957</b> to <b>April 22, 1958</b> that I last saw the deceased alive on <b>April 12, 1958</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.  |                               | ADDRESS (Street, city or town, state) <b>2. Parkway Dr. Forest Hgt. Md.</b> DATE SIGNED  |   |
| ACTUAL SIGNATURE <b>Dr. Etienne Bolen</b>   |                               | PHYSICIAN'S NAME (Type) <b>Dr. Etienne Szollosi</b>  |   |
| 22a. BURIAL, CREMATION, REPOSYMENT Specify <b>Burial</b>  |                               | 22b. DATE THEREOF <b>4-26-58</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Wash. Nat.</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Seat Land, Md</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b> ADDRESS <b>D.C.</b>  |                               | 24a. REC'D BY REGISTRAR DATE <b>APR 28 '58</b>   |   |
| 24b. REGISTRAR'S SIGNATURE <b>Redman</b>  |                               |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64922

Reg. Dist. No.

4912

|   |                              |  |  |   |  |  |   |
|---|------------------------------|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> <b>MARYLAND</b>   |                              |  |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. George</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Laurel</b>   |                              | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>41 Laurel</b>  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Laurel General Hospital</b>  |                              |  |  | d. STREET ADDRESS<br><b>409 Main Stree</b>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Stewart</b> Middle <b>Davis</b> Last <b>Long</b>  |                              |  |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>19</b> Year <b>1958</b>   |  |  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>October 26, 1893</b>   |  | 9. AGE (In years last birthday)<br><b>64</b> yrs.                        | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Accountant (retired)</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Accounting</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                               |   |
| 13. FATHER'S NAME<br><b>Allen Marion Long</b>   |                              |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Frances Irene Stewart</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>[ ]</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>[ ]</b>  |  | 17. INFORMANT<br><b>Mrs. Margaret Travers Hyattsville, Md</b>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>442X Acute congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-vascular renal disease</b><br>DUE TO<br>(c) <b>[ ]</b>  |                              |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>[ ]</b>  |                              |  |  |   |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                     |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                              |  |  |   |  |  |   |
| ACTUAL SIGNATURE <b>John T. Maloney</b>   |                              |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |   |
| EXAMINER'S NAME (Type) <b>John T. Maloney, MD</b>   |                              |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |   |
|   |                              |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 19, 1958</b>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 22b. DATE THEREOF<br><b>April 21, 1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Congressional Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. Donaldson Laurel Md</b>   |                              |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 22 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. Donaldson</b>                        |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU K. S.

APR 28 1939

RECEIVED

## 4881 CERTIFICATE OF DEATH

Reg. Dist. No. 04923

|   |                           |   |                                 |
|---|---------------------------|---|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George's                        |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hyattsville, Maryland   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>15 Hyattsville, Md.   |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>Hyattsville Nursing Home  |                           | d. STREET ADDRESS<br>4305 Oglethrope St   |                                 |
| 3. NAME OF DECEASED (Type or print)<br>First Theodore Middle Loschiavo Last   |                           | 4. DATE OF DEATH<br>Month April Day 8, Year 1958  |                                 |
| 5. SEX<br>male  | 6. COLOR OR RACE<br>white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Nov 2, 1881 |
| 9. AGE (In years lost birthday) yrs.<br>76  |                           | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Tile setter  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Sicily   |                                 |
| 11. BIRTHPLACE (State or foreign country)<br>Sicily   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U S A   |                                 |
| 13. FATHER'S NAME<br>Joseph Loschiavo   |                           | 14. MOTHER'S MAIDEN NAME<br>Unknown   |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO.   |                                 |
| 17. INFORMANT<br>Leo Loschiavo  |                           | Address<br>College Park, Md.  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 450.0 DUE TO Congestive Heart Failure 6 mos.<br>Conditions, if any, which gave rise to immediate cause (b) General arteriosclerosis 10 yr.<br>cause (c) Cerebral thrombosis 2 yrs.<br>lying cause lost.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                           |   |                                 |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |   |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                 |
| 21. I certify that I attended the deceased from Dec 1955 to Apr 8 1958, that I last saw the deceased alive on Apr 6 1958, and that death occurred at M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>L W Malin M.D.  |                           |   |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 22b. DATE THEREOF<br>April 19, 1958   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln Cemetery   |                           | 22d. LOCATION (City, town, or county) (State)<br>Colmar Manor, Md.  |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>F. Gasch's Sons   |                           | 24a. REC'D BY REGISTRAR<br>DATE APR 11 '58  |                                 |
| 24b. REGISTRAR'S SIGNATURE<br>R. Gasch  |                           |   |                                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 11 1958

BUREAU V. S.

Form with multiple sections and fields, mostly illegible due to heavy ink smudges and bleed-through. Visible text includes "BUREAU V. S." and "APR 11 1958".

Form with multiple sections and fields, mostly illegible due to heavy ink smudges and bleed-through. Visible text includes "BUREAU V. S." and "APR 11 1958".

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4913 CERTIFICATE OF DEATH

Reg. Dist. No.

04924

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George's</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY                                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>  |   | c. LENGTH OF STAY IN 1b <u>3y. 1mo. 16d.</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3v01-4</u> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>   |   | d. STREET ADDRESS <u>503 Beaumont Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 3. NAME OF DECEASED (Type or print) <u>Augusta</u> <u>Lyles</u>   |   | 4. DATE OF DEATH <u>April</u> <u>7</u> <u>1958</u>   |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>           | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH <u>May 15-1868</u> <u>89</u>                            |
| 9. AGE (In years last birthday) <u>89</u> yrs.  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME   |   | 14. MOTHER'S MAIDEN NAME   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u>  |   | 16. SOCIAL SECURITY NO. <u>—</u>   |  |
| 17. INFORMANT <u>Dr. Newland E. Day - Baltimore - Maryland</u>  |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>332x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u><br>DUE TO <u>With Psychosis</u><br>(c) |   | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u><br><u>many years</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. 19  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>2-22</u> , 19 <u>55</u> , to <u>Mar 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Mar. 7</u> , 19 <u>58</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above.  |   |  |  |
| ACTUAL SIGNATURE <u>Jesse C. Coggins</u> M.D.   |   | ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u> DATE SIGNED <u>4/7/58</u>   |  |
| PHYSICIAN'S NAME (Type) <u>JESSE C. COGGINS</u>   |   | <u>LAUREL - MARYLAND</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>April 10, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Jenkins &amp; Sons, Inc., 4905 York Road</u>   |   | 24a. REC'D BY REGISTRAR <u>DATE APR 9 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. E. ...</u>  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04925

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |                                  |   |  |   |  |   |  |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>35 Years</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>15 Hyattsville</b>                                   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>4004 Jefferson Street</b>   |                                  |   |  | d. STREET ADDRESS<br><b>4004 Jefferson Street</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Henry</b> Middle <b>Hyde</b> Last <b>Lyon</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>6</b> Year <b>1958</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>November 11, 1896</b> 61 yrs.  |  | 9. AGE (in years last birthday)   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Engineer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Radio</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Hyattsville, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Wallace Chittenden Lyon</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Helen Butzman</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Dorothy Lyon Jones; 4303 Emerson Street,</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>442 X Acute congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b><br>(a), stating the underlying cause last. DUE TO (c)   |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>  |                                  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|  |                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4/9/1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Prince Georges County, Md.</b>                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co.-2901 14th St., N.W.</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br><b>APR 8 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOX 1416  
HEALTH UNIT

11

RECEIVED  
MAY 10 1958

U.S. DEPARTMENT OF HEALTH  
DIVISION OF VETERANS AFFAIRS

11

U.S. DEPARTMENT OF HEALTH  
DIVISION OF VETERANS AFFAIRS

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible] SEX: [illegible] AGE: [illegible]

RESIDENCE: [illegible]

DATE OF DEATH: [illegible]

TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CITY: [illegible] STATE: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE OF DEATH: [illegible]

UNDERLYING CAUSE OF DEATH: [illegible]

BUREAU V. 5

APR 8 1958

RECEIVED

## 4914 CERTIFICATE OF DEATH

04926

Reg. Dist. No.

|  |                                    |   |   |
|--|------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> <b>MARYLAND</b>  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bladensburg,</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General</b>   |                                    | d. STREET ADDRESS<br><b>5209 Tilden Road</b>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Efrosine</b> Middle <b>Malakatis</b> Last <b>Malakatis</b>   |                                    | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>2</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/14/96</b>  |
| 9. AGE (In years last birthday)<br><b>61</b> yrs.  |                                    | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Greece</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                    | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Marcos Malakatis</b>   |                                    | Address <b>5209 Tilden Rd. Bladensburg, Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PERICARDITIS CHRONIC</b><br><b>705.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LUPUS ERYTHEMATOSIS</b> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mos.</b><br><b>5 years</b> |                                    |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Nov. 1</b> , 19 <b>57</b> , to <b>APRIL 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>April 2</b> , 19 <b>58</b> , and that death occurred at <b>8:55 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |                                    |   |   |
| ACTUAL SIGNATURE <b>Norman D. Comeau</b> M.D.  |                                    |   |   |
| PHYSICIAN'S NAME (Type) <b>Norman D. Comeau, M. D.</b>   |                                    | <b>3303 Perry Street, Mt. Rainier, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   | 22b. DATE THEREOF<br><b>4/5/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Prince Georges, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S. H. Hines Co.</b>   |                                    | ADDRESS<br><b>2901-14th St. N.W.</b>  | 24a. REC'D BY REGISTRAR<br><b>DATE</b> <b>APR 7 '58</b>                     |
|  |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Quelch</b>   |   |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

8-1-58

**RECEIVED**  
 APR 2 1958  
 BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4883

## CERTIFICATE OF DEATH

## 04927

Reg. Dist. No.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Pr. Geo.</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>   |  | c. LENGTH OF STAY IN 1b <u>33 yrs.</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4210 Jefferson St.</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Barton Hirst Marshall</u>  |  | 4. DATE OF DEATH <u>April 28 1958</u>  |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>24 Feb 1893</u>                                     |
| 9. AGE (In years last birthday) <u>65</u> yrs.  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Engg.</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Va.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>James K.</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Hirst</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>W.W.I</u> <u>45-38-3095</u>   |   |
| 17. INFORMANT <u>Earla B. Marshall</u>  |  | Address <u>Same as #2</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u><br>DUE TO <u>1551.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma bile ducts</u><br>DUE TO (c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u><br><u>5 mos.</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that I attended the deceased from <u>Jan 3</u> , 19 <u>58</u> , to <u>April 28</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>April 28</u> , 19 <u>58</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.  |  |  |   |
| ACTUAL SIGNATURE <u>Harry N. Carter</u> , M.D.  |  | ADDRESS (Street, city or town, state) <u>1816 R St., N.W. Wash, D.C.</u> DATE SIGNED <u>April 28, 1958</u>   |   |
| PHYSICIAN'S NAME (Type) _____   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>May 1, 1958</u>   | 22c. NAME OF CEMETERY OR CREMATORIUM <u>Arlington National</u>   | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md.</u>  |  | 24a. REC'D BY REGISTRAR <u>MAY 2 '58</u>   | 24b. REGISTRAR'S SIGNATURE <u>Earla B. Marshall</u>                     |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|  |  |   |
|--|--|---|
| NAME OF DECEASED<br><i>John H. Smith</i>     |  | DATE OF DEATH<br><i>Jan 15 1928</i>             |
| AGE<br><i>33</i>                             |  | SEX<br><i>Male</i>                              |
| RACE<br><i>White</i>                         |  | EDUCATION<br><i>High School</i>                 |
| OCCUPATION<br><i>Teacher</i>                 |  | RESIDENCE<br><i>1234 Main St, Baltimore, Md</i> |
| CAUSE OF DEATH<br><i>Heart Disease</i>       |  | PLACE OF DEATH<br><i>Home</i>                   |
| MANNER OF DEATH<br><i>Natural</i>            |  | DATE OF BURIAL<br><i>Jan 17 1928</i>            |
| PLACE OF BURIAL<br><i>Greenwood Cemetery</i> |  | NAME OF MINISTER<br><i>Rev. J. H. Jones</i>     |
| NAME OF PHYSICIAN<br><i>Dr. J. H. Jones</i>  |  | NAME OF CORONER<br><i>John H. Smith</i>         |
| NAME OF REGISTRAR<br><i>John H. Smith</i>    |  | NAME OF CLERK<br><i>John H. Smith</i>           |

4915

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>8 hrs</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mazzie</b> Middle <b>McCleave</b> Last <b>McCleave</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>2</b> Year <b>19 58</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Black</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>?</b>   |
| 9. AGE (In years last birthday)<br><b>48 ? yrs.</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>?</b> Days <b>?</b> Hours <b>?</b> Min. <b>?</b>   | 11. IF UNDER 24 HRS.<br>Months <b>?</b> Days <b>?</b> Hours <b>?</b> Min. <b>?</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSEWIFE</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>REV. WILLIAM M. PARROTT</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Charlotte CURBEAN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>(If yes, give war or dates of service)</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>C. MC CLEAVE LAUREL, MD.</b>  |  |
| 17. INFORMANT<br><b>C. MC CLEAVE LAUREL, MD.</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cerebral vascular accident</b><br>331X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>(found unconscious by relatives)</b><br>DUE TO<br>(c) <b>relatives</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>4/2</b> , 19 <b>58</b> , to <b>4/2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/2</b> , 19 <b>58</b> , and that death occurred at <b>12 38A</b> M, from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE <b>Dr. C. L. Mendel</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>7506 College Ave</b> DATE SIGNED <b>4/3/58</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Dr. C. L. Mendel M D</b>   |                                  | <b>College Park Md</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF                | 22c. NAME OF CEMETERY OR CREMATORY  | 22d. LOCATION (City, town, or county) (State)                                      |
| <b>Burial April 6 1958</b>  | <b>April 6 1958</b>              | <b>Mt. Zion Cross Road</b>  | <b>Chester S. C</b>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bradley Selby</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>APR 8 '58</b>   |  |
| ADDRESS   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Alberson</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1958

1958

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1958

1958

BUREAU V. S.

APR 8 1958

RECEIVED

CONFIDENTIAL

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04929

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY4916  
Prince Georges

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Pr. Geo.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Riverdale

c. LENGTH OF STAY IN 1b

1/2 hr.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

College Park

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Leland Memorial Hospital

d. STREET ADDRESS

8806 49th Avenue

e. IS RESIDENCE  
ON A FARM?YES ☐ NO ☒3. NAME OF  
DECEASED  
(Type or print)

First

Harry

Middle

Wilbert

Last

McNamee

4. DATE  
OF  
DEATH

Month

April

Day

6th,

Year

19 58

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Nov. 24, 1873

9. AGE (In years  
last birthday)

84 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Merchant

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Israel McNamee

14. MOTHER'S MAIDEN NAME

Martha Singleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212-20-0887

17. INFORMANT

Address

David McNamee; University Hills, W. Hyattsville

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Hemorrhage and shock

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause lost.

(b)

Gunshot wound of head

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Self inflicted gunshot wound of head

20c. TIME OF INJURY

Month, Day, Year

Hour ☒ p.m. 4-6- 58

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

Home

20f. (City or town)

College Park, Pr. Geo. Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐ACTUAL  
SIGNATURE

John T. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

April 6, 1958

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREAT

4/8/58

22c. NAME OF CEMETERY OR CREMATORY

ort Lincoln Cemetery

22d. LOCATION (City, town, or county)

Colmar Manor, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR

APR 8 '58

24b. REGISTRAR'S SIGNATURE

W. F. Schuch

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-10-1958

DATE OF DEATH: 10-10-1958

TIME OF DEATH: 10:00 AM

PLACE OF DEATH: 8800 North Avenue

DECEASED'S NAME: [illegible]

SEX: [illegible]

AGE: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF EXAMINATION: [illegible]

BUREAU V. S.

APR 8 1958

RECEIVED

## 4954 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont-Hgts</u>  |  |  |  | c. LENGTH OF STAY IN TB <u>20 yrs</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5701 JOST ST.</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Lucy</u> First <u>GREEN</u> Middle <u>MEDLEY</u> Last   |  |  |  | 4. DATE OF DEATH <u>Apr.</u> Month <u>14</u> Day <u>1958</u> Year  |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>Colored</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>OCT. 20 1895</u>                                     |  |
| 9. AGE (in years last birthday) <u>62</u> yrs.   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <u>Dublin Georgia</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                  |  |
| 13. FATHER'S NAME <u>William Wilcher</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Sallie Wiley</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)   |  | 17. INFORMANT <u>Jessie Medley</u>   |  | Address <u>5702 JOST ST</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>163X</u> <u>carcinoma of lungs</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>carcinoma of RT. MAMMA</u><br><u>Generalized Carcinomatosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hyper-tension</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u><br><u>18 mo</u> |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. 19   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I attended the deceased from <u>Mar. 28</u> , 19 <u>58</u> , to <u>April 14</u> , 19 <u>58</u> that I last saw the deceased alive on <u>April 14</u> , 19 <u>58</u> , and that death occurred at <u>9:30</u> P.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Washington 19-D.C.</u> DATE SIGNED <u>H.C. Beldon</u>  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>H.C. Beldon</u> M.D. <u>4823 HUNT-PI. NE</u>   |  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>H.C. Beldon</u> <u>Washington 19-D.C.</u>   |  |  |  |  |  |  |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>H-18-58</u>  |  | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Berming Rd SE. D.C.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry L. Washington &amp; Sons</u> ADDRESS <u>467 N st. N.W.</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>APR 17 1958</u> DATE  |  | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED<br><i>John W. Smith</i>         |  | 2. SEX<br><i>Male</i>                              |  | 3. AGE<br><i>45</i>                                 |  |
| 4. DATE OF DEATH<br><i>April 15, 1953</i>           |  | 5. TIME OF DEATH<br><i>10:30 AM</i>                |  | 6. PLACE OF DEATH<br><i>Home</i>                    |  |
| 7. CAUSE OF DEATH<br><i>Myocardial Infarction</i>   |  | 8. MANNER OF DEATH<br><i>Natural</i>               |  | 9. SIGNATURE OF PHYSICIAN<br><i>Dr. J. H. Jones</i> |  |
| 10. SIGNATURE OF REGISTRAR<br><i>John W. Smith</i>  |  | 11. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 12. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 13. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 14. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 15. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 16. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 17. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 18. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 19. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 20. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 21. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 22. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 23. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 24. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 25. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 26. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 27. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 28. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 29. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 30. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 31. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 32. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 33. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 34. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 35. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 36. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 37. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 38. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 39. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 40. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 41. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 42. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 43. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 44. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 45. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 46. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 47. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 48. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 49. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 50. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 51. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 52. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 53. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 54. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 55. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 56. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 57. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 58. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 59. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 60. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 61. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 62. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 63. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 64. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 65. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 66. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 67. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 68. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 69. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 70. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 71. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 72. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 73. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 74. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 75. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 76. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 77. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 78. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 79. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 80. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 81. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 82. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 83. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 84. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 85. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 86. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 87. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 88. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 89. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 90. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 91. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 92. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 93. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 94. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  | 95. SIGNATURE OF DECEASED<br><i>John W. Smith</i>  |  | 96. SIGNATURE OF WITNESSES<br><i>John W. Smith</i>  |  |
| 97. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  | 98. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 99. SIGNATURE OF DECEASED<br><i>John W. Smith</i>   |  |
| 100. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  | 101. SIGNATURE OF DECEASED<br><i>John W. Smith</i> |  | 102. SIGNATURE OF WITNESSES<br><i>John W. Smith</i> |  |

RECEIVED  
BUREAU V. S.  
APR 17 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4917

## CERTIFICATE OF DEATH

Reg. Dist. No.

04931

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Prince George</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Penna.</b><br>b. COUNTY                             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pittsburgh, 75 X - 3</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | d. STREET ADDRESS<br><b>739 - Hazelwood Avenue</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Emma</b> Middle <b>G</b> Last <b>Miller</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>19</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 27, 1885</b> |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>at Home</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>John Fiser</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Rose Spanbach</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Hospital Records</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac tamponade. (rupt. Post Left Ventr.)</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Infarction Left Ventr. post. due to</b><br>DUE TO<br>(c) <b>Thrombotic occl. Rl. cor. At 2 ASD.</b>   |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>April 18, 19 58</b> to <b>April 19, 19 58</b> , that I last saw the deceased alive on <b>April 18, 19 58</b> , and that death occurred at <b>10:10 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Benjamin S. Miller</b> <b>3824 - 34th St. Pittsburgh Ind 4-19-58</b><br>M.D.<br>ACTUAL SIGNATURE<br>PHYSICIAN'S NAME (Type) <b>Benjamin S. Miller, M. D.</b> |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                  | 22b. DATE THEREOF<br><b>4/19/58</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Homestead Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Homestead, Pennsylvania</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S. H. Hines Co.</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>Washington, D. C.</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Reed Smith</b>  |                                  | DATE<br><b>April 19 1958</b>  |  |

# CERTIFICATE OF DEATH

1

BUREAU V. 3

APR 21 1958

RECEIVED

## CERTIFICATE OF DEATH

04932

Reg. Dist. No.

4918

|   |                                  |   |                                      |  |   |   |  |
|---|----------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Prince Georges County</b>  |                                  | MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Maryland</b> |   | b. COUNTY<br><b>Prince Georges</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>18 days</b>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Hill</b>               |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>  |                                  | d. STREET ADDRESS<br><b>1434 St. Barina St</b>  |                                      |  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>William E Mulloy</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>April 24 19 58</b>   |                                      |  |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/14/1900</b> |  | 9. AGE (In years last birthday)<br><b>57</b> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Steamfitter</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Wehrle Plumbers</b>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Arthur D. Mulloy</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annia Teresa Shea</b>  |                                      |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                      | 17. INFORMANT<br><b>Arthur D. Mulloy, Jr., 2010 Upshur St. N.E.</b>  |   | Address <b>Wash. DC</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Adeno Carcinoma</b><br>199.2 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary undetermined</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |                                  |   |                                      |  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |                                      |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from _____, 19____, to <b>4/24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/24</b> , 19 <b>58</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.   |                                  |   |                                      |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Leon R. Levitsky</b>   |                                  | M.D. <b>3408 Rhode Island; 44 Rainier, MD 4/25/58</b>   |                                      | DATE SIGNED  |   |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Leon R. Levitsky</b>  |                                  |   |                                      |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4/28/1958</b>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Nat'l Cem.</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland Rd. Pr. Geo. Co., Md.</b>            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.W. Chambers Company, Riverdale, Md.</b>  |                                  | ADDRESS   |                                      | 24a. REC'D BY REGISTRAR<br><b>DATE APR 28 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Alfred Smith</b>   |  |

MEDICAL CERTIFICATION

2

1

VS A15 (4)  
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

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77

I

CERTIFICATE OF DEATH

DEATH BOND

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of death: \_\_\_\_\_

5. Place of death: \_\_\_\_\_

6. Cause of death: \_\_\_\_\_

7. Signature of physician: \_\_\_\_\_

8. Signature of registrar: \_\_\_\_\_

BUREAU V. S.

APR 28 1938

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04933

4955

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Maryland Park</u>   | c. LENGTH OF STAY IN 1b<br><u>10 years</u>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Maryland Park</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>107-64th Street</u>   |   | d. STREET ADDRESS<br><u>107-64th Street</u>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Sarah</u> First <u>Hunter</u> Middle <u>Muntau</u> Last <u>Sough</u>  |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>1</u> Year <u>1958</u>  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 13, 1892</u>   |
| 9. AGE (In years last birthday)<br><u>66</u> yrs.  |   | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>58</u>  | IF UNDER 24 HRS.<br>Hours <u>1</u> Min. <u>58</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own home</u>  | 11. BIRTHPLACE (State or foreign country)<br><u>Ireland</u>                                       |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   | 13. FATHER'S NAME<br><u>Robert Hunter</u>   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)                                |   |
| 16. SOCIAL SECURITY NO.<br><u>none</u>   |   | 17. INFORMANT<br><u>Aileen Longo</u> Address <u>Same as #2</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u><br><u>442X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal deca</u><br>(a), stating the underlying cause last. DUE TO (c)  |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>  |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE<br><u>James I. Boyd</u>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type)<br><u>JAMES I. BOYD</u>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   | 22b. DATE THEREOF<br><u>4-5-1958</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Washington National</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Switzland, Maryland</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W.W. Chambers, Co. Washington, D.C.</u>   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 7 '58</u>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Alfred</u>  |   | DATE SIGNED<br><u>April 2, 1958</u>   |   |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND



BUREAU V. 2

APR 7 1958

RECEIVED

4956

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGE</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>KENSINGTON</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X KENSINGTON</u>                                    |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>10310 FAWCETT ST</u> |  | d. STREET ADDRESS<br><u>10310 FAWCETT ST</u>   |  |
|   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Mary A NORRIS</u>                                |                                  | 4. DATE OF DEATH<br>Month Day Year<br><u>April 16 19 58</u>  |   |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1-21-1877</u>                                |
| 9. AGE (In years last birthday) <u>81</u> yrs.  |                                  | IF UNDER 1 YEAR  | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>  | 11. BIRTHPLACE (State or foreign country)<br><u>BUCKEYS TOWN MD</u> |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                  |  |   |
| 13. FATHER'S NAME<br><u>JAMES TRAIL</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>CATHERINE CARTER</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>                                 |                                  | 16. SOCIAL SECURITY NO.<br><u>574-12-8501</u>  |   |
| 17. INFORMANT<br><u>ALLEN NORRIS ABOVE RESIDENCE</u>  |                                  | Address  |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u><br><u>421.4</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Heart Failure, Auricular Fibrillation</u><br>DUE TO (c) <u>Incompetence all Heart Valves, Sclerosis</u> |  | INTERVAL BETWEEN ONSET AND DEATH                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19 p. m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State)  |  |  |

|  |  |
|--|--|
| 21. I certify that I attended the deceased from <u>Mar 7</u> , 19 <u>58</u> , to <u>Apr 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Mar 25</u> , 19 <u>58</u> , and that death occurred at <u>6:55 a.m.</u> , from the causes and on the date stated above. |  |
| ADDRESS (Street, city or town, state)  | DATE SIGNED                                |
| ACTUAL SIGNATURE <u>Robert T. Thibadeau</u> M.D.   | <u>10609 Concord St.</u> <u>Apr 16, 58</u> |
| PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D.</u> <u>Kensington, Md.</u>  |  |

|   |                                       |  |   |
|---|---------------------------------------|--|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 22b. DATE THEREOF<br><u>4-18-1958</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>WASH NATL CEM</u> | 22d. LOCATION (City, town, or county) (State)<br><u>SUITLAND MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W.W. Chambers Co</u> |                                       | ADDRESS <u>Wash D.C.</u><br><u>3072 M St NW</u>            | 24a. REC'D BY REGISTRAR<br><u>APR 21 58</u>                         |
|   |                                       | 24b. REGISTRAR'S SIGNATURE<br><u>W. H. ...</u>             |   |

O.K. by Dr. Bresschard (Med Ex)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1953

BUREAU V. 2

APR 21 1953

RECEIVED

## 4957 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Brandywine</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Brandywine</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | d. STREET ADDRESS   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Maudie</u> Middle <u>Lee</u> Last <u>Padgett</u>  |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>25</u> Year <u>1958</u>   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Can</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 23, 1905</u>  |
| 9. AGE (In years last birthday)<br><u>53</u> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>D. Buckler</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Birdie</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>—</u>   |  |
| 17. INFORMANT<br><u>John W. Padgett</u>   |   | Address<br><u>Brandywine, Md.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Vessel Disease</u><br>DUE TO (c) <u>—</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>12</u><br><u>yes</u>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>—</u>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>—</u>  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. — 19<br>p. m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>2-8</u> 19 <u>56</u> to <u>4-26</u> 19 <u>58</u> , that I last saw the deceased alive on <u>4-26</u> 19 <u>58</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Brandywine, Md.</u> DATE SIGNED            |   |   |  |
| ACTUAL SIGNATURE <u>Rene K. Doherty</u> M.D.  |   | PHYSICIAN'S NAME (Type) <u>Rene K. Doherty</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>4-28-58</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>OLD FIELDS cem</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Hughesville MD.</u>                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Huntt Funeral Home, Woldorf, Md.</u>   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 29 1958</u>  | 24b. REGISTRAR'S SIGNATURE<br><u>W. J. ...</u>   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU**

APR 29 1958

RECEIVED  
APR 29 1958

4919 CERTIFICATE OF DEATH

04936

Reg. Dist. No.

|  |                               |   |                                       |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>            |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Riverdale</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>14 College Park</u>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Eugene Leland Memorial Hospital</u>   |                               | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Albert</u> Middle <u>J.</u> Last <u>Patrick</u>  |                               | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>21</u> Year <u>1958</u>   |                                       |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>wt</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12-16-1895</u> |
| 9. AGE (In years lost birthday)<br><u>62</u> yrs.  |                               | 10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Pharmacist</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Maryland</u>  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |                                       |
| 13. FATHER'S NAME<br><u>John J. Patrick</u>  |                               | 14. MOTHER'S MAIDEN NAME<br><u>Heilman</u>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><u>  </u>   |                               | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><u>  </u>   |                                       |
| 17. INFORMANT<br><u>Hospital</u>   |                               | Address<br><u>Riverdale, Ind.</u>   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>acute coronary thrombosis with perforation of L. ventricle - 4 days</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart dis</u><br>(c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>abdominal aortic aneurysm</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> |                               |   |                                       |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                               |   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |   |                                       |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                               |   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>  |                               | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <u>apr 16, 1958</u> to <u>apr 21, 1958</u> , that I last saw the deceased alive on <u>apr 20, 1958</u> , and that death occurred at <u>2:40</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Riverdale, Ind.</u> DATE SIGNED <u>4-21-58</u>   |                               |   |                                       |
| ACTUAL SIGNATURE <u>L W Malin</u> M.D. <u>Riverdale, Ind.</u>  |                               |   |                                       |
| PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>  |                               |   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                               | 22b. DATE THEREOF<br><u>4/23/58</u>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln Cemetery</u>   |                               | 22d. LOCATION (City, town, or county) (State)<br><u>Colmar Manor, Md.</u>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>F. Gasch's Sons</u>   |                               | ADDRESS<br><u>Hyattsville Maryland.</u>   |                                       |
| 24a. REC'D BY REGISTRAR<br>DATE <u>APR 23 '58</u>  |                               | 24b. REGISTRAR'S SIGNATURE<br><u>  </u>   |                                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4884 CERTIFICATE OF DEATH

04937

Reg. Dist. No.

|   |                        |  |                             |
|---|------------------------|--|-----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Md b. COUNTY Prince Georges                            |                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville  |                        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 905-Chillum Road  |                             |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 905-Chillum Road  |                        | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             |
| 3. NAME OF DECEASED (Type or print) First Middle Last Wenzel Pfohl  |                        | 4. DATE OF DEATH Month 4 Day 24 Year 1958  |                             |
| 5. SEX male   | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/22, 1886 |
| 9. AGE (In years last birthday) 72 yrs.   |                        | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Broker  |                        | 10b. KIND OF BUSINESS OR INDUSTRY Retired  |                             |
| 11. BIRTH PLACE (State or foreign country) Bohemia  |                        | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |                             |
| 13. FATHER'S NAME Joseph  |                        | 14. MOTHER'S MAIDEN NAME Francisca   |                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                        | 16. SOCIAL SECURITY NO. 57-903-4965  |                             |
| 17. INFORMANT Son   |                        | 905-Chillum Rd Hyattsville Md  |                             |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.0 DUE TO myocardial infarction<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease<br>(c) membranous Glomerulonephritis |                        | INTERVAL BETWEEN ONSET AND DEATH instantaneous 10 years 3 years  |                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                        |  |                             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                             |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |                        | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                             |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |                             |
| 21. I certify that I attended the deceased from Jan. 1957, to April 1958, that I last saw the deceased alive on 4/16, 1958, and that death occurred at 11:25 P.M. from the causes and on the date stated above.   |                        |  |                             |
| ACTUAL SIGNATURE Henry B. Wolfe   |                        | M.D. APR 1 25 1958   |                             |
| PHYSICIAN'S NAME (Type) HENRY R. WOLFE  |                        | 905-Sheridan Street Hyattsville Md.  |                             |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                        | 22b. DATE THEREOF 4/28/58  |                             |
| 22c. NAME OF CEMETERY OR CREMATORY Washington National  |                        | 22d. LOCATION (City, town, or county) (State) Suitland Md.   |                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home  |                        | ADDRESS Mr. Rainier Md.  |                             |
| 24a. REC'D BY REGISTRAR DATE APR 28 '58   |                        | 24b. REGISTRAR'S SIGNATURE   |                             |

CERTIFICATE OF DEATH

|                       |  |                          |  |                          |  |                       |  |                    |  |                        |  |                                  |  |                             |  |
|-----------------------|--|--------------------------|--|--------------------------|--|-----------------------|--|--------------------|--|------------------------|--|----------------------------------|--|-----------------------------|--|
| NAME OF DECEASED      |  | DATE OF BIRTH            |  | SEX                      |  | RACE                  |  | MARRIAGE           |  | EDUCATION              |  | OCCUPATION                       |  | RESIDENCE                   |  |
| JAMES H. HARRIS       |  | JAN 15 1895              |  | M                        |  | W                     |  | MARRIED            |  | HIGH SCHOOL            |  | LABORER                          |  | BALTIMORE, MD.              |  |
| PLACE OF DEATH        |  | DATE OF DEATH            |  | HOUR OF DEATH            |  | CAUSE OF DEATH        |  | MANNER OF DEATH    |  | PLACE OF BURIAL        |  | DATE OF BURIAL                   |  | NAME OF FUNERAL HOME        |  |
| HOME                  |  | APR 10 1938              |  | 10:00 AM                 |  | HEART DISEASE         |  | NATURAL            |  | CATHOLIC CHURCH        |  | APR 12 1938                      |  | JAMES H. HARRIS             |  |
| PREVIOUS ILLNESS      |  | DATE OF ONSET            |  | DATE OF LAST EXAMINATION |  | NAME OF PHYSICIAN     |  | NAME OF HOSPITAL   |  | NAME OF NURSE          |  | NAME OF ASSISTANT                |  | NAME OF ATTENDING PHYSICIAN |  |
| NONE                  |  | APR 5 1938               |  | APR 10 1938              |  | DR. J. H. HARRIS      |  | NONE               |  | NONE                   |  | NONE                             |  | DR. J. H. HARRIS            |  |
| SIGNATURE OF DECEASED |  | SIGNATURE OF NEXT OF KIN |  | SIGNATURE OF PHYSICIAN   |  | SIGNATURE OF HOSPITAL |  | SIGNATURE OF NURSE |  | SIGNATURE OF ASSISTANT |  | SIGNATURE OF ATTENDING PHYSICIAN |  | SIGNATURE OF FUNERAL HOME   |  |
| JAMES H. HARRIS       |  | JAMES H. HARRIS          |  | JAMES H. HARRIS          |  | JAMES H. HARRIS       |  | JAMES H. HARRIS    |  | JAMES H. HARRIS        |  | JAMES H. HARRIS                  |  | JAMES H. HARRIS             |  |

BUREAU V. S.

APR 28 1938

RECEIVED

4958 CERTIFICATE OF DEATH

Reg. Dist. No.

04938

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>D. C.</b> b. COUNTY <b>-</b>                        |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glenn Dale (rural)</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>1 yr., 4 mos., &amp; 19 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Glenn Dale Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>423 3rd St., S. W.</b>   |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Frank</b> Middle <b>-</b> Last <b>Posey</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>8</b> Year <b>19 58</b>  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/15/1908</b>                                     |  |
| 9. AGE (In years last birthday)<br><b>50</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b> |  | IF UNDER 24 HRS.<br>Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Francis Burrows Contractor</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Willie Johnson</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mell Posey</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>223-28-1307</b>  |  | 17. INFORMANT<br><b>Decedent</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-</b> (c) <b>-</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema and cor pulmonale</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 yrs., 2 mo.,</b>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>-</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town)  |  |   |  | 20g. (County)  |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <b>11/20</b> , 19 <b>56</b> , to <b>4/8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/8</b> , 19 <b>58</b> , and that death occurred at <b>4:14</b> PM, from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Moe Weiss</b>   |  |   |  | ADDRESS (Street, city or town, state)<br><b>Glenn Dale Hospital</b>  |  |  |  |
| DATE SIGNED<br><b>4/8/58</b>   |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Moe Weiss, M. D.</b>   |  |   |  | Glenn Dale, Md.  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 22b. DATE THEREOF<br><b>4/15/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>D. C. Morgue</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington D. C.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Moe Weiss (M.D.)</b>  |  |   |  | ADDRESS<br><b>Glenn Dale, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>APR 17 '58</b>                             |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Reese</b>   |  |   |  |  |  |  |  |

RECEIVED

## 4920 CERTIFICATE OF DEATH

Reg. Dist. No. 04930

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b><br>c. LENGTH OF STAY IN 1b<br><b>14 Days</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prs George</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bladensburg 33</b><br>d. STREET ADDRESS<br><b>4110 53rd Ave. Apt 1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Andrew</b> Middle <b>Rager</b> Last<br>4. DATE OF DEATH<br>Month <b>April</b> Day <b>28</b> Year <b>1958</b>  |  | 5. SEX<br><b>Male</b> 6. COLOR OR RACE<br><b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH<br><b>11-20-1898</b> 9. AGE (In years last birthday)<br><b>59</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b> 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Naval Gun factory</b> 11. BIRTHPLACE (State or foreign country)<br><b>Pa</b> 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>      |  | 13. FATHER'S NAME<br><b>Linus Rager</b> 14. MOTHER'S MAIDEN NAME<br><b>Jessie Marrow</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>-</b> 16. SOCIAL SECURITY NO.<br><b>-</b> 17. INFORMANT<br><b>Lillian Rager</b> Address<br><b>Bladensburg Md</b>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PERITONITIS</b><br><b>550.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ruptured Appendix</b><br>DUE TO (c) <b>Acute Appendicitis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>14 DAYS</b><br><b>14 days</b><br><b>15 days</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Emphysema of Lungs</b> 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>MARCH</b> , 19 <b>51</b> , to <b>APRIL 28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>APRIL 28</b> , 19 <b>58</b> , and that death occurred at <b>8:20 A</b> . M, from the causes and on the date stated above. |  |   |  |
| ACTUAL SIGNATURE<br><b>Norman D. Coneau</b> M.D. 3503 6th St. NW   |  | DATE SIGNED<br><b>4/28/58</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Norman Coneau</b>  |  | <b>MT Rainer md</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b> 22b. DATE THEREOF<br><b>4/28/58</b> 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln</b> 22d. LOCATION (City, town, or county) (State)<br><b>Colmar Manor, Md</b>   |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. G. G. Sons</b> ADDRESS<br><b>Hyattsville Md</b> 24a. REC'D BY REGISTRAR<br><b>DATE APR 29 '58</b> 24b. REGISTRAR'S SIGNATURE<br><b>W. H. G. G.</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

## CERTIFICATE OF DEATH

BUREAU V. B.

APR 29 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04940

Reg. Dist. No.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale</b>  |  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>14 College Park</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Leland Memorial Hospital</b>   |  |   |  | d. STREET ADDRESS<br><b>9024 49th Place</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harold</b> Middle <b>Charles</b> Last <b>Rich</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>16</b> Year <b>1958</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Oct. 24, '03</b>   |  |
| 9. AGE (In years last birthday)<br><b>54</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min.                                   |  | IF UNDER 24 HRS.<br>Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Meatcutter</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Meat</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Michigan</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Harry Howard Rich</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Payment</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>578-05-0713</b>   |  | 17. INFORMANT<br><b>Elizabeth Rich; same address.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Renal Disease</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____        |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m. _____   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____   |  | 20f. (City or town) _____ (County) _____ (State) _____  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>   |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 17, 1958</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>April 19, 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Colmar Manor, Md.</b>                         |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b>  |  |   |  | ADDRESS<br><b>Hyattsville Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>6221 '58</b>  |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. J. ...</b>   |  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate with the Registrar. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Registrar. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text elements.

BUREAU V. 3

APR 21 1959

RECEIVED

# MARYLAND STATE CERTIFICATE OF HEALTH—BALTIMORE, 18

## 4922 CERTIFICATE OF DEATH

Reg. Dist. No. **04941**

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Prince George</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md</b> b. COUNTY <b>PG</b>                             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly, Md</b>   |   | c. LENGTH OF STAY IN 1b<br><b>54 Days</b>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>33 Bladensburg, Md</b>   |   | d. STREET ADDRESS<br><b>1 5512 Randolph St.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Prince George General Hospital</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Marjorie</b> Middle <b>A.</b> Last <b>Richardson</b>  |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>30</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 1, 1908</b>                                   |
| 9. AGE (In years from birthday) yrs. <b>49</b>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Months Days Hours Min.                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Oak Grove, Virginia</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>William Gudridge</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Josephine (unknown)</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>---</b>   |   |
| 17. INFORMANT<br><b>Milton R. Richardson</b>  |   | Address <b>5512 Randolph Street, Cheverly, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic failure</b><br><b>581.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PORTAL CIRRHOSIS</b> DUE TO<br>(c) <b>---</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b><br><b>3 years</b>         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PORTO CAVAL ANASTOMOSIS</b> <b>1 April 58</b>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>20 MAR 1958</b> , to <b>30 Apr 1958</b> , that I last saw the deceased alive on <b>30 April 1958</b> , and that death occurred at <b>11:35 AM</b> from the causes and on the date stated above.  |   |   |   |
| ACTUAL SIGNATURE<br><b>John H. Bayly</b>  |   | ADDRESS (Street, city or town, state)<br><b>1835 EYE N.W. WASH DC</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>JOHN H. BAYLY</b>   |   | DATE SIGNED<br><b>30 Apr 58</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>May 5, 1958</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James T. Ryan, Inc.</b>  |   | ADDRESS<br><b>317 Pa Ave, SE DC3</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>MAY 5 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Overman</b>  |   |

MEDICAL CERTIFICATION

I 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                                |  |                                   |  |                                   |  |
|--------------------------------|--|-----------------------------------|--|-----------------------------------|--|
| 1. NAME OF DECEASED            |  | 2. SEX                            |  | 3. AGE                            |  |
| 4. PLACE OF BIRTH              |  | 5. OCCUPATION                     |  | 6. MARITAL STATUS                 |  |
| 7. DATE OF DEATH               |  | 8. TIME OF DEATH                  |  | 9. CAUSE OF DEATH                 |  |
| 10. PLACE OF DEATH             |  | 11. SIGNATURE OF PHYSICIAN        |  | 12. SIGNATURE OF REGISTRAR        |  |
| 13. SIGNATURE OF WITNESSES     |  | 14. SIGNATURE OF CORONER          |  | 15. SIGNATURE OF JURY             |  |
| 16. SIGNATURE OF DECEASED      |  | 17. SIGNATURE OF NEXT OF KIN      |  | 18. SIGNATURE OF BURIAL OFFICIAL  |  |
| 19. SIGNATURE OF FUNERAL HOME  |  | 20. SIGNATURE OF CHURCH           |  | 21. SIGNATURE OF CEMETERY         |  |
| 22. SIGNATURE OF MINISTERS     |  | 23. SIGNATURE OF MUSICIANS        |  | 24. SIGNATURE OF FLORISTS         |  |
| 25. SIGNATURE OF COFFIN MAKERS |  | 26. SIGNATURE OF CARRIAGE DRIVERS |  | 27. SIGNATURE OF BURIAL OFFICIALS |  |
| 28. SIGNATURE OF INTERVIEWERS  |  | 29. SIGNATURE OF INTERVIEWERS     |  | 30. SIGNATURE OF INTERVIEWERS     |  |
| 31. SIGNATURE OF INTERVIEWERS  |  | 32. SIGNATURE OF INTERVIEWERS     |  | 33. SIGNATURE OF INTERVIEWERS     |  |
| 34. SIGNATURE OF INTERVIEWERS  |  | 35. SIGNATURE OF INTERVIEWERS     |  | 36. SIGNATURE OF INTERVIEWERS     |  |
| 37. SIGNATURE OF INTERVIEWERS  |  | 38. SIGNATURE OF INTERVIEWERS     |  | 39. SIGNATURE OF INTERVIEWERS     |  |
| 40. SIGNATURE OF INTERVIEWERS  |  | 41. SIGNATURE OF INTERVIEWERS     |  | 42. SIGNATURE OF INTERVIEWERS     |  |
| 43. SIGNATURE OF INTERVIEWERS  |  | 44. SIGNATURE OF INTERVIEWERS     |  | 45. SIGNATURE OF INTERVIEWERS     |  |
| 46. SIGNATURE OF INTERVIEWERS  |  | 47. SIGNATURE OF INTERVIEWERS     |  | 48. SIGNATURE OF INTERVIEWERS     |  |
| 49. SIGNATURE OF INTERVIEWERS  |  | 50. SIGNATURE OF INTERVIEWERS     |  | 51. SIGNATURE OF INTERVIEWERS     |  |
| 52. SIGNATURE OF INTERVIEWERS  |  | 53. SIGNATURE OF INTERVIEWERS     |  | 54. SIGNATURE OF INTERVIEWERS     |  |
| 55. SIGNATURE OF INTERVIEWERS  |  | 56. SIGNATURE OF INTERVIEWERS     |  | 57. SIGNATURE OF INTERVIEWERS     |  |
| 58. SIGNATURE OF INTERVIEWERS  |  | 59. SIGNATURE OF INTERVIEWERS     |  | 60. SIGNATURE OF INTERVIEWERS     |  |
| 61. SIGNATURE OF INTERVIEWERS  |  | 62. SIGNATURE OF INTERVIEWERS     |  | 63. SIGNATURE OF INTERVIEWERS     |  |
| 64. SIGNATURE OF INTERVIEWERS  |  | 65. SIGNATURE OF INTERVIEWERS     |  | 66. SIGNATURE OF INTERVIEWERS     |  |
| 67. SIGNATURE OF INTERVIEWERS  |  | 68. SIGNATURE OF INTERVIEWERS     |  | 69. SIGNATURE OF INTERVIEWERS     |  |
| 70. SIGNATURE OF INTERVIEWERS  |  | 71. SIGNATURE OF INTERVIEWERS     |  | 72. SIGNATURE OF INTERVIEWERS     |  |
| 73. SIGNATURE OF INTERVIEWERS  |  | 74. SIGNATURE OF INTERVIEWERS     |  | 75. SIGNATURE OF INTERVIEWERS     |  |
| 76. SIGNATURE OF INTERVIEWERS  |  | 77. SIGNATURE OF INTERVIEWERS     |  | 78. SIGNATURE OF INTERVIEWERS     |  |
| 79. SIGNATURE OF INTERVIEWERS  |  | 80. SIGNATURE OF INTERVIEWERS     |  | 81. SIGNATURE OF INTERVIEWERS     |  |
| 82. SIGNATURE OF INTERVIEWERS  |  | 83. SIGNATURE OF INTERVIEWERS     |  | 84. SIGNATURE OF INTERVIEWERS     |  |
| 85. SIGNATURE OF INTERVIEWERS  |  | 86. SIGNATURE OF INTERVIEWERS     |  | 87. SIGNATURE OF INTERVIEWERS     |  |
| 88. SIGNATURE OF INTERVIEWERS  |  | 89. SIGNATURE OF INTERVIEWERS     |  | 90. SIGNATURE OF INTERVIEWERS     |  |
| 91. SIGNATURE OF INTERVIEWERS  |  | 92. SIGNATURE OF INTERVIEWERS     |  | 93. SIGNATURE OF INTERVIEWERS     |  |
| 94. SIGNATURE OF INTERVIEWERS  |  | 95. SIGNATURE OF INTERVIEWERS     |  | 96. SIGNATURE OF INTERVIEWERS     |  |
| 97. SIGNATURE OF INTERVIEWERS  |  | 98. SIGNATURE OF INTERVIEWERS     |  | 99. SIGNATURE OF INTERVIEWERS     |  |
| 100. SIGNATURE OF INTERVIEWERS |  | 101. SIGNATURE OF INTERVIEWERS    |  | 102. SIGNATURE OF INTERVIEWERS    |  |



## 4923 CERTIFICATE OF DEATH

04942

Reg. Dist. No.

|  |                                  |  |                                    |  |   |
|--|----------------------------------|--|------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Prince George</b> |   |
| c. LENGTH OF STAY IN 1b<br><b>23 Hrs</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>23 Greenbelt</b>  |                                    | d. STREET ADDRESS<br><b>37 E Ridge Road</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Nelson Oliver Roberts</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>4-5-1958</b>  |                                    |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-12-43</b> | 9. AGE (In years last birthday)<br><b>14</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>   |   |
| 13. FATHER'S NAME<br><b>Wayne A Roberts</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Beatrice Grisham</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |                                    | 17. INFORMANT<br><b>Wayne Roberts 37-E-Ridge Rd. Greenbelt, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive intracranial hemorrhage (left temporal)</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hemorrhagic diathesis</b><br>DUE TO (c) <b>Acute lymphatic leukemia</b> |                                  |  |                                    |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours.</b><br><b>1 month</b><br><b>5 months.</b>         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |                                    |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>4/15</b>  |   |
| 20f. (City or town)<br><b>4/15</b>   |                                  | 20g. (County)<br><b>5:58 PM</b>  |                                    | 20h. (State)<br><b>4/15</b>  |   |
| 21. I certify that I attended the deceased from <b>4/15</b> , 19 <b>58</b> , to <b>4/15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/15</b> , 19 <b>58</b> , and that death occurred at <b>5:58 PM</b> , from the causes and on the date stated above.  |                                  |  |                                    |  |   |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>Cheverly, Md.</b>  |                                    | DATE SIGNED<br><b>4/16/58</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>John Kehoe</b>   |                                  | <b>Cheverly, Md.</b>   |                                    |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4/9/1958</b>   |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l Cem.</b>  |   |
| 22d. LOCATION (City, town, or county)<br><b>Arlington, Virginia</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 10 '58</b>  |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>W.W. Chambers</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.W. Chambers Company, Riverdale, Md.</b>   |                                  | ADDRESS<br><b>Riverdale, Md.</b>   |                                    |  |   |

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2

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

Date of Death

Place of Death

Decedent's Name

Sex

Age

Usual Residence

Occupation

Marital Status

Cause of Death

Manner of Death

Place of Burial

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Medical Examiner

Signature of Funeral Director

Signature of Undertaker

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

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Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

BUREAU V. S.

APR 10 1958

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04943

Reg. Dist. No.

4924

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY Pr. Geo.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

15 Hyattsville

d. STREET ADDRESS

5509 43rd Place

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒3. NAME OF  
DECEASED  
(Type or print)

First Austin

Middle Levi

Last Roth

4. DATE  
OF  
DEATH

Month

Day

Year

April

11

19 58

## 5. SEX

Male

## 6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

## 8. DATE OF BIRTH

5-27-01

9. AGE (In years  
last birthday)

56 yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

## 10b. KIND OF BUSINESS OR INDUSTRY

Refrigeration

## 11. BIRTHPLACE (State or foreign country)

Pennsylvania

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Levi H. Roth

## 14. MOTHER'S MAIDEN NAME

Carrie Gotwalt

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

72-01-1397

## 17. INFORMANT

Address

Phyllis Funkhouser; Hyattsville, Md.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute congestive heart failure

DUE TO

442x  
Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Cardiovascular renal disease

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN  
ONSET AND DEATH20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour a. m.  
p. m.

Month, Day, Year

19

## 20d. INJURY OCCURRED

While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

John T. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

April 13, 1958

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

April 15, 1958

## 22c. NAME OF CEMETERY OR CREMATORY

Mt Rose Cemetery

## 22d. LOCATION (City, town, or county)

York Pennsylvania

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons Hyattsville Md.

## ADDRESS

## 24a. REC'D BY REGISTRAR

DATE APR 14 '58

## 24b. REGISTRAR'S SIGNATURE

C. J. ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1958

NAME OF DECEASED: Levi H. Rosen

DATE OF DEATH: 10-21-1958

PLACE OF DEATH: Home

RESIDENTIAL ADDRESS: 1000 North ...

CITY: Baltimore

COUNTY: Harford

STATE: Md.

AGE: 71

SEX: M

RACE: W

EDUCATION: High School

OCCUPATION: Retired

RELIGION: Methodist

DATE OF BIRTH: 10-21-1958

PLACE OF BIRTH: ...

DATE OF DEATH: 10-21-1958

PLACE OF DEATH: Home

RESIDENTIAL ADDRESS: 1000 North ...

CITY: Baltimore

COUNTY: Harford

STATE: Md.

AGE: 71

SEX: M

RACE: W

EDUCATION: High School

OCCUPATION: Retired

RELIGION: Methodist

DATE OF BIRTH: 10-21-1958

PLACE OF BIRTH: ...

RECEIVED  
OCT 24 1958  
BUREAU K.B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4925

## CERTIFICATE OF DEATH

Reg. Dist. No. 04944

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James P.</b> Middle <b>Sanford</b> Last <b>Sanford</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>18</b> Year <b>19 58</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>24 June 1905</b> |
| 9. AGE (In years last birthday)<br><b>52</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>52</b> Days <b>52</b> Hours <b>52</b> Min. <b>52</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Engineer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Safeway Stores Inc Virginia</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>Ryland Sanford</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ada Scrimger</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>578-07-2080</b>   |   |
| 17. INFORMANT<br><b>Ells Louise Sanford</b>  |                                  | Address <b>6510 C St Maryland PK. Md</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410X Congestive Heart Failure</b><br>DUE TO (b) <b>Myocardial Heart Disease</b><br>DUE TO (c) <b>10 yrs (?)</b>        |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>April 10, 19 58</b> to <b>April 18, 19 58</b> , that I last saw the deceased alive on <b>April 18, 19 58</b> , and that death occurred at <b>1.00A M.</b> from the causes and on the date stated above. |                                  |   |   |
| ACTUAL SIGNATURE<br><b>William Brainin M.D.</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>6124 Central Ave</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. William Brainin M.D.</b>   |                                  | DATE SIGNED<br><b>4/18/58</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4-21-58</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland, Maryland</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. W. Chambers Co.</b>  |                                  | ADDRESS<br><b>517-11- St. S.E.</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>APR 21 '58</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>W. W. Chambers</b>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. The funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

APR 21 1939

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4885 CERTIFICATE OF DEATH

04945

Reg. Dist. No.

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGE</u> MARYLAND  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>W. HYATTSVILLE</u>   |                                  |   | c. LENGTH OF STAY IN 1b<br><u>9 YRS</u>  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>6105 EASTERN AVENUE</u>  |                                  |   | e. STREET ADDRESS<br><u>16105 EASTERN AVE</u>  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>BERTHA</u> First <u>MIERE</u> Middle <u>SCHAEFFER</u> Last   |                                  |   | 4. DATE OF DEATH <u>APRIL</u> Month <u>19</u> Day <u>1958</u> Year   |  |  |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>JULY 20, 1851</u>   |  | 9. AGE (In years lost birthday)<br><u>106</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOMEMAKER</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>GERMANY</u>            |  |
| 13. FATHER'S NAME<br><u>MIERE</u>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>NOT AVAILABLE</u>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>MISS JOSEPHINE V. SCHAEFFER (Daughter #2)</u>      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.<br>(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO<br>(c) <u>GENERALIZED ARTERIOSCLEROSIS</u> |                                  |   |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>3 MONTHS</u><br><u>30 YRS.</u><br><u>50 YRS.</u>   |                                  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>SQUAMOUS CELL CARCINOMA OF SKIN</u>   |                                  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)   |                                  | (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <u>4/18</u> , 19 <u>58</u> , to <u>4/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/18</u> , 19 <u>58</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.   |                                  |   |  |  |  |
| ACTUAL SIGNATURE <u>Seymour Greenbaum</u>   |                                  | ADDRESS (Street, city or town, state) <u>9300 EWING DRIVE, BETHESDA, MD.</u> DATE SIGNED <u>4/19/58</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>SEYMOUR GREENBAUM, M.D.</u>  |                                  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>April 22, 1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Olivet Cemetery</u>     |  |
| 22d. LOCATION (City, town, or county)<br><u>Washington, D.C.</u>  |                                  | (State)   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Arthur Walters, 254 Carroll Ave. N.W. D.C.</u>   |                                  | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 22 '58</u>                      |  |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur Walters</u>                    |  |

TO MARRIAGE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                            |  |                            |  |                           |  |                               |  |                            |  |
|----------------------------|--|----------------------------|--|---------------------------|--|-------------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED        |  | 2. SEX                     |  | 3. AGE                    |  | 4. RACE                       |  | 5. OCCUPATION              |  |
| 6. PLACE OF BIRTH          |  | 7. DATE OF BIRTH           |  | 8. DATE OF DEATH          |  | 9. TIME OF DEATH              |  | 10. CAUSE OF DEATH         |  |
| 11. PLACE OF DEATH         |  | 12. MANNER OF DEATH        |  | 13. MEDICAL HISTORY       |  | 14. PRESENT ILLNESS           |  | 15. TREATMENT              |  |
| 16. SIGNATURE OF PHYSICIAN |  | 17. SIGNATURE OF WITNESSES |  | 18. SIGNATURE OF DECEASED |  | 19. SIGNATURE OF FUNERAL HOME |  | 20. SIGNATURE OF REGISTRAR |  |

BUREAU V. S.

APR 22 1968

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4959

04946

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George                       |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Forestville  |  | c. LENGTH OF STAY IN 1b<br>18 years  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Forestville  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>5404 Spring Street   |  |  |  | d. STREET ADDRESS<br>5404 Spring Street  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Edna Gertrude Schwenk  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br>April 15 19 58   |  |  |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>White  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>September 27/1889 68 yrs.  |  |
| 9. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |
| 13. FATHER'S NAME<br>George Green  |  |  |  | 14. MOTHER'S MAIDEN NAME<br>? Michael  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>No   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)  |  | 17. INFORMANT<br>1710 22nd Street S.E.<br>Earl L. Schwenk, Washington, D.C.  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 442x Acute congestive heart failure<br>DUE TO (b) Cardiovascular renal disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>James I. Boyd  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.<br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  |  | DATE SIGNED<br>April 15, 1958  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Buried  |  | 22b. DATE THEREOF<br>4-18-58   |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill   |  | 22d. LOCATION (City, town, or county) (State)<br>Suitland Md                                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Seminole Bros  |  | ADDRESS<br>1661 Good Hope Rd SE<br>Wash. DC  |  | 24a. REC'D BY REGISTRAR<br>DATE APR 17 '58   |  | 24b. REGISTRAR'S SIGNATURE<br>Allrich  |  |

RECEIVED

APR 17 1953

BUREAU V. 2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1953

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
TITLE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4960

## CERTIFICATE OF DEATH

Reg. Dist. No. 04947

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Prince George</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Adelphi</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>X Adelphi</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>2615 Cool Spring Road</b>  |                                  | d. STREET ADDRESS<br><b>2615 Cool Spring Road</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>HOMER P. SEAMAN</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>April 2 1958</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 21, 1890</b> |
| 9. AGE (In years lost birthday)<br><b>67</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Steam Fitter</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Penn.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Thomas Seaman</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Plotner</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><b>220-34-8306</b>   |  |
| 17. INFORMANT<br>Address<br><b>Gertrude Seaman 2615 Cool Spring Rd.</b>   |                                  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mins.</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Feb. 12</b> , 19 <b>58</b> , to <b>Apr. 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>April 2</b> , 19 <b>58</b> , and that death occurred at <b>2 P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Charles C. Hageage</b> M.D. <b>3308 Perry St., Mt. Rainier, Md.</b> <b>4/2/58</b>            |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Charles C. Hageage</b>   |                                  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>CHARLES C. HAGEAGE M.D.</b>   |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>4/5/58</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Bladensburg Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. Frank Joy Co.</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>APR 8 1958</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>W. J. Seaman</b>   |                                  |   |  |

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mirrored and difficult to read.

BUREAU V. B.

APR 8 1958

RECEIVED

*Handwritten signature or initials*

4926

## CERTIFICATE OF DEATH

04948

Reg. Dist. No.

|   |  |   |  |   |  |  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b>  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b> |  | c. LENGTH OF STAY IN 1b<br><b>12 hours</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Maryland</b>   |  | b. COUNTY<br><b>Prince George</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>16 Mt. Rainier</b> |  | d. STREET ADDRESS<br><b>14207 Russell Avenue</b>                                |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Doris</b><br>Middle <b>Stromeyer</b><br>Last <b>Skinner</b>   |  | 4. DATE OF DEATH<br>Month <b>4</b><br>Day <b>11</b><br>Year <b>19 58</b>                            |  | 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11-12-08</b>   |  | 9. AGE (In years last birthday)<br><b>49</b> yrs.                               |  | 10. IF UNDER 1 YEAR<br>Months <b>4</b><br>Days <b>11</b><br>Hours <b>19</b><br>Min. <b>58</b>     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Kan-</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 13. FATHER'S NAME<br><b>Fred. HAYMAN</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Erma Helfrich</b>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b> |  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |  |
| 17. INFORMANT<br><b>PERCY H. SKINNER</b>  |  | Address<br><b>4207 Russell Rd. Mt. Rainier</b>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b><br>DUE TO <b>Acute myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>   |  |   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)        |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><b>Switland</b>  |  | (County)<br><b>MD</b>   |  | (State)   |  |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>6:30P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br>ACTUAL SIGNATURE <b>Norman H. Rubenstein</b> M.D.<br>PHYSICIAN'S NAME (Type) _____ |  |   |  |   |  |  |  |   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>4-14-58</b>   |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 22d. LOCATION (City, town, or county)<br><b>Switland</b>   |  | (State)<br><b>MD</b>  |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>JWM. Lee Sons - 424 Mass N.E. Washington D.C.</b>                  |  | 24a. REC'D BY REGISTRAR<br><b>APR 15 '58</b>                                    |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. Leach</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

APR 15 1958

RECEIVED

4961 CERTIFICATE OF DEATH

## MEDICAL CERTIFICATION

VS A15 (4)  
ISM 9/SS

# CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH—Baltimore, 13

13-100-110

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED<br>Mary V. S.       |  | 2. SEX<br>Female   |  | 3. AGE<br>45                              |  | 4. PLACE OF BIRTH<br>Maryland             |  |
| 5. DATE OF DEATH<br>April 11, 1958      |  | 6. TIME OF DEATH<br>10:00 AM   |  | 7. PLACE OF DEATH<br>Home                 |  | 8. CAUSE OF DEATH<br>Heart Disease        |  |
| 9. DISEASE OR INJURY<br>Heart Disease   |  | 10. PERIOD OF ILLNESS<br>2 weeks                                     |  | 11. PLACE OF ILLNESS<br>Home              |  | 12. SIGNATURE OF PHYSICIAN<br>J. H. Smith |  |
| 13. SIGNATURE OF DECEASED<br>Mary V. S. |  | 14. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 15. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 16. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 17. SIGNATURE OF DECEASED<br>Mary V. S. |  | 18. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 19. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 20. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 21. SIGNATURE OF DECEASED<br>Mary V. S. |  | 22. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 23. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 24. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 25. SIGNATURE OF DECEASED<br>Mary V. S. |  | 26. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 27. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 28. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 29. SIGNATURE OF DECEASED<br>Mary V. S. |  | 30. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 31. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 32. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 33. SIGNATURE OF DECEASED<br>Mary V. S. |  | 34. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 35. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 36. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 37. SIGNATURE OF DECEASED<br>Mary V. S. |  | 38. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 39. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 40. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 41. SIGNATURE OF DECEASED<br>Mary V. S. |  | 42. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 43. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 44. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 45. SIGNATURE OF DECEASED<br>Mary V. S. |  | 46. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 47. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 48. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 49. SIGNATURE OF DECEASED<br>Mary V. S. |  | 50. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 51. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 52. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 53. SIGNATURE OF DECEASED<br>Mary V. S. |  | 54. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 55. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 56. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 57. SIGNATURE OF DECEASED<br>Mary V. S. |  | 58. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 59. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 60. SIGNATURE OF CLERK<br>J. H. Smith     |  |
| 61. SIGNATURE OF DECEASED<br>Mary V. S. |  | 62. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 63. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 64. SIGNATURE OF CLERK<br>J. H. Smith     |  |
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| 97. SIGNATURE OF DECEASED<br>Mary V. S. |  | 98. SIGNATURE OF WITNESSES<br>J. H. Smith, M.D.<br>J. H. Smith, M.D. |  | 99. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 100. SIGNATURE OF CLERK<br>J. H. Smith    |  |

BUREAU V. 2

APR 11 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4927

Reg. Dist. No.

04950

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

D.O.A.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Pr. Geo,

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

d. STREET ADDRESS

7906 15th Avenue

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒

3. NAME OF  
DECEASED  
(Type or print)

David

Poole

Smith

4. DATE  
OF  
DEATH

April

2,

1958

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

March 7, 1906

9. AGE (In years  
last birthday)

52  
yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Automobile

11. BIRTHPLACE (State or foreign country)

N. Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Jeffries Smith

14. MOTHER'S MAIDEN NAME

Cora Ann Poole

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, no, or unknown)

Yes

16. SOCIAL SECURITY NO.  
(If yes, give year or dates of service)

W.W. 2.

17. INFORMANT

Address

James C. Smith; 4 H Southway Rd., Greenbelt,

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute congestive heart failure

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Cardiovascular renal disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN  
ONSET AND DEATH

Md.

20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour a. m.  
p. m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL  
SIGNATURE

John T. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

April 2, 1958

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/8/58

22c. NAME OF CEMETERY OR INTERMENT

Arlington National

22d. LOCATION (City, town, or county)

Arlington Virginia

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

F. Gasch's Sons Hyattsville Md.

24a. REC'D BY REGISTRAR

APR 7 '58

24b. REGISTRAR'S SIGNATURE

W. E. Seuch

FOR STATE  
HEALTH DEPT.

RECEIVED  
MAY 1958

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: James H. Smith  
2. Date of Death: March 7, 1958  
3. Place of Death: Home  
4. Age: 45  
5. Sex: Male  
6. Race: White  
7. Occupation: Engineer  
8. Cause of Death: Myocardial Infarction  
9. Manner of Death: Natural  
10. Signature of Medical Examiner: John T. Johnson, M.D.  
11. Signature of Coroner: James H. Smith  
12. Signature of Registrar: John T. Johnson

RECEIVED  
APR 7 1958  
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4962

## CERTIFICATE OF DEATH

Reg. Dist. No. 04951

|  |  |   |  |  |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>D. C.</u> b. COUNTY <u>—</u>                        |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glenn Dale (rural)</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>5 months and 16 days</u>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Glenn Dale Hospital</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u> <u>47X-3</u>                                       |  |   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | d. STREET ADDRESS<br><u>515 Que St., N. W.</u>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>James</u> Middle <u>T.</u> Last <u>Smith</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>17</u> Year <u>19 58</u>   |  |   |   |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>Negro</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>5/23/03</u>  |   |
| 9. AGE (In years last birthday)<br><u>54</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>                             |  | IF UNDER 24 HRS.<br>Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Ace Wrecking Co.</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Washington, D. C.</u>     |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |   |  |  |  |   |   |
| 13. FATHER'S NAME<br><u>Andrew Stewart</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Emma Smith</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>   |  | 17. INFORMANT<br><u>Decedent</u>   |  | Address <u>—</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of pyriform sinus and pharynx</u><br>DUE TO (b) <u>199.2</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002X</u> DUE TO (c) <u>—</u> |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 months</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Pulmonary tuberculosis, 4 yrs.,</u>  |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u>—</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                      |   |
| 21. I certify that I attended the deceased from <u>11/1/</u> , 19 <u>57</u> , to <u>4/17/</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/17/</u> , 19 <u>58</u> , and that death occurred at <u>7:05 AM</u> , from the causes and on the date stated above.   |  |   |  |  |  |   |   |
| ACTUAL SIGNATURE <u>Moe Weiss</u>  |  |   |  | ADDRESS (Street, city or town, state)<br><u>Glenn Dale Hospital</u>  |  | DATE SIGNED<br><u>4/17/58</u>   |   |
| PHYSICIAN'S NAME (Type)<br><u>Moe Weiss, M. D.</u>   |  |   |  | Glenn Dale, Md.  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>4/22/58</u>  |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Fort. Clinton Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Washington, D. C.</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Johnson &amp; Jenkins</u>   |  |   |  | ADDRESS<br><u>4804 G.A. Rd.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 22 '58</u>                         |   |
|  |  |   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>W. H. Redner</u>                         |   |

CERTIFICATE OF DEATH

|                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |
|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED       |  | AGE                    |  | SEX                    |  | RACE                   |  | DATE OF BIRTH          |  | PLACE OF BIRTH         |  | CITY OF BIRTH          |  | STATE OF BIRTH         |  | COUNTRY OF BIRTH       |  |
| MARRIAGE               |  | MARRIED                |  | MARRIED                |  | MARRIED                |  | MARRIED                |  | MARRIED                |  | MARRIED                |  | MARRIED                |  | MARRIED                |  |
| CAUSE OF DEATH         |  | CAUSE OF DEATH         |  | CAUSE OF DEATH         |  | CAUSE OF DEATH         |  | CAUSE OF DEATH         |  | CAUSE OF DEATH         |  | CAUSE OF DEATH         |  | CAUSE OF DEATH         |  | CAUSE OF DEATH         |  |
| MANNER OF DEATH        |  | MANNER OF DEATH        |  | MANNER OF DEATH        |  | MANNER OF DEATH        |  | MANNER OF DEATH        |  | MANNER OF DEATH        |  | MANNER OF DEATH        |  | MANNER OF DEATH        |  | MANNER OF DEATH        |  |
| PLACE OF DEATH         |  | PLACE OF DEATH         |  | PLACE OF DEATH         |  | PLACE OF DEATH         |  | PLACE OF DEATH         |  | PLACE OF DEATH         |  | PLACE OF DEATH         |  | PLACE OF DEATH         |  | PLACE OF DEATH         |  |
| DATE OF DEATH          |  | DATE OF DEATH          |  | DATE OF DEATH          |  | DATE OF DEATH          |  | DATE OF DEATH          |  | DATE OF DEATH          |  | DATE OF DEATH          |  | DATE OF DEATH          |  | DATE OF DEATH          |  |
| TIME OF DEATH          |  | TIME OF DEATH          |  | TIME OF DEATH          |  | TIME OF DEATH          |  | TIME OF DEATH          |  | TIME OF DEATH          |  | TIME OF DEATH          |  | TIME OF DEATH          |  | TIME OF DEATH          |  |
| SIGNATURE OF DECEASED  |  | SIGNATURE OF DECEASED  |  | SIGNATURE OF DECEASED  |  | SIGNATURE OF DECEASED  |  | SIGNATURE OF DECEASED  |  | SIGNATURE OF DECEASED  |  | SIGNATURE OF DECEASED  |  | SIGNATURE OF DECEASED  |  | SIGNATURE OF DECEASED  |  |
| SIGNATURE OF WITNESS   |  | SIGNATURE OF WITNESS   |  | SIGNATURE OF WITNESS   |  | SIGNATURE OF WITNESS   |  | SIGNATURE OF WITNESS   |  | SIGNATURE OF WITNESS   |  | SIGNATURE OF WITNESS   |  | SIGNATURE OF WITNESS   |  | SIGNATURE OF WITNESS   |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF PHYSICIAN |  |
| SIGNATURE OF CORONER   |  | SIGNATURE OF CORONER   |  | SIGNATURE OF CORONER   |  | SIGNATURE OF CORONER   |  | SIGNATURE OF CORONER   |  | SIGNATURE OF CORONER   |  | SIGNATURE OF CORONER   |  | SIGNATURE OF CORONER   |  | SIGNATURE OF CORONER   |  |
| SIGNATURE OF JUDGE     |  | SIGNATURE OF JUDGE     |  | SIGNATURE OF JUDGE     |  | SIGNATURE OF JUDGE     |  | SIGNATURE OF JUDGE     |  | SIGNATURE OF JUDGE     |  | SIGNATURE OF JUDGE     |  | SIGNATURE OF JUDGE     |  | SIGNATURE OF JUDGE     |  |
| SIGNATURE OF CLERK     |  | SIGNATURE OF CLERK     |  | SIGNATURE OF CLERK     |  | SIGNATURE OF CLERK     |  | SIGNATURE OF CLERK     |  | SIGNATURE OF CLERK     |  | SIGNATURE OF CLERK     |  | SIGNATURE OF CLERK     |  | SIGNATURE OF CLERK     |  |

RECEIVED  
APR 22 1958  
BUREAU V. 2

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4886 CERTIFICATE OF DEATH

Reg. Dist. No. 04952

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 15   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION  |                                   | d. STREET ADDRESS <u>4864-66<sup>th</sup> Avenue</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Joseph</u> Last <u>Spates</u>  |                                   | 4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1958</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>March 23, 1904</u> 5-4 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assessor</u>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Govt</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>   |                                   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>John Spates</u>  |                                   | 14. MOTHER'S MAIDEN NAME <u>Eleanor Carroll</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>Yes WW II</u>   |                                   | 16. SOCIAL SECURITY NO. <u>214-14-4419</u>   |  |
| 17. INFORMANT <u>Thelma Spates</u> Address <u>4864-66<sup>th</sup> Avenue Hyattsville Md</u>  |                                   | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas with generalized metastasis</u><br>157X DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>Nov. 1956</u> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>November, 1956</u> , to <u>April 6, 1958</u> , that I last saw the deceased alive on <u>April 3, 1958</u> , and that death occurred at <u>259</u> M, from the causes and on the date stated above. |                                   |  |  |
| ACTUAL SIGNATURE <u>William D. Rosson M.D.</u>  |                                   | ADDRESS (Street, city or town, state) <u>5304 Annapolis Road</u> DATE SIGNED <u>4/6/1958</u>   |  |
| PHYSICIAN'S NAME (Type) <u>William D. Rosson, M.D.</u>  |                                   | <u>Bladensburg, Maryland</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>4-9-1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Heights</u>  |  |
| 22d. LOCATION (City, town, or county) (State) <u>28 in Md</u>   |                                   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Mottley</u> ADDRESS <u>Washington, D.C.</u>   |                                   | 24a. REC'D BY REGISTRAR DATE <u>APR 9 58</u>   |  |
|   |                                   | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |

CERTIFICATE OF DEATH

|                          |  |                         |  |
|--------------------------|--|-------------------------|--|
| NAME OF DECEASED         |  | DATE OF DEATH           |  |
| RESIDENCE                |  | PLACE OF DEATH          |  |
| OCCUPATION               |  | CAUSE OF DEATH          |  |
| AGE                      |  | SEX                     |  |
| RACE                     |  | RELIGION                |  |
| MARRIAGE                 |  | EDUCATION               |  |
| BIRTH                    |  | DEATH                   |  |
| FATHER                   |  | MOTHER                  |  |
| SISTER                   |  | BROTHER                 |  |
| CHILDREN                 |  | GRANDCHILDREN           |  |
| PARENTS                  |  | GRANDPARENTS            |  |
| Siblings                 |  | Other relatives         |  |
| Social history           |  | Medical history         |  |
| Mental history           |  | Physical examination    |  |
| Laboratory tests         |  | X-ray examination       |  |
| Pathological examination |  | Microscopic examination |  |
| Toxicology               |  | Immunology              |  |
| Genetics                 |  | Infectious diseases     |  |
| Neoplasms                |  | Endocrine system        |  |
| Cardiovascular system    |  | Respiratory system      |  |
| Gastrointestinal system  |  | Genitourinary system    |  |
| Musculoskeletal system   |  | Integumentary system    |  |
| Sensory system           |  | Nervous system          |  |
| Immune system            |  | Hematological system    |  |
| Endocrine system         |  | Reproductive system     |  |
| Other                    |  | Other                   |  |

BUREAU V. S.

APR 9 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4963 CERTIFICATE OF DEATH

Reg. Dist. No.

04953

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>D. C.</b> b. COUNTY <b>-</b>                        |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glenn Dale (rural)</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>2 yrs., 4 months, &amp; 19 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Glenn Dale Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>4031 Alabama Ave., S. E.</b>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>A.</b> Last <b>Steiger</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>28</b> Year <b>19 58</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/1/02</b>  |  |
| 9. AGE (In years last birthday)<br><b>56 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>                |  | IF UNDER 24 HRS.<br>Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plate printer</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Driesenstock</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>William Steiger</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Marie Seebode</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>Decedent</b>   |  | Address <b>-</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency</b><br>DUE TO (b) <b>Acute pneumonia, right lung</b><br>DUE TO (c) <b>Acute pneumonia, right lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>pulmonary emphysema, 3 yrs; basal cell carcinoma, left cheek, 3 yrs., 9 months</b> |  |  |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>2 days</b>  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>12/9/</b> , 19 <b>55</b> , to <b>4/28/</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/28/</b> , 19 <b>58</b> , and that death occurred at <b>5:00 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b> DATE SIGNED <b>4/28/58</b><br>ACTUAL SIGNATURE <b>Glenn Dale Hospital</b> M.D. <b>Glenn Dale, Md.</b><br>PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF<br><b>May 1, 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Congressional Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>18 Potomac Ave. S.E. Washington D.C.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Halley's Funeral Home Inc. Mt Rainier</b>   |  |  |  | 24. REC'D BY REGISTRAR<br><b>MAY - 1958</b>  |  | 24. REGISTRAR'S SIGNATURE<br><b>Glenn Dale</b>   |  |



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4928

CERTIFICATE OF DEATH

Reg. Dist. No.

04954

|  |                                  |   |  |  |  |   |  |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <i>Prince George's</i> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Hyattsville</i>   |                                  | c. LENGTH OF STAY IN 1b<br><i>1 year</i>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>15 Hyattsville</i>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>4119 Woodberry Street</i>   |                                  |   |  | d. STREET ADDRESS<br><i>1 4119 Woodberry Street</i>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Lissa</i> Middle <i>(W.M.N.)</i> Last <i>Teder</i>   |                                  |   |  | 4. DATE OF DEATH<br>Month <i>April</i> Day <i>13</i> Year <i>1958</i>  |  |   |  |
| 5. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>Cauc.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>April 7, 1895</i>   |  | 9. AGE (In years lost birthday) yrs. <i>63</i>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>   |  | 11. BIRTHPLACE (State or foreign country)<br><i>ESTONIA</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>ESTONIA</i>  |  |
| 13. FATHER'S NAME<br><i>Jaan Laas</i>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Mari (Unknown)</i>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>no</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>none</i>  |  | 17. INFORMANT<br>Address<br><i>Mrs. Teise Hantsoo, 4119 Woodberry, Hyattsville</i>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i><br>DUE TO (c) <i>Generalized arteriosclerosis</i> |                                  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>1/2 hour</i><br><i>5 years</i><br><i>10 years</i>          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i>   |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
|  |                                  |   |  | 20f. (City or town)  |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <i>March 31, 1958</i> , to <i>April 13, 1958</i> , that I last saw the deceased alive on <i>April 12, 1958</i> , and that death occurred at <i>4:45 P.M.</i> from the causes and on the date stated above.   |                                  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>Eino Magi</i>   |                                  |   |  | ADDRESS (Street, city or town, state)<br><i>918 University Blvd. E.</i>  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><i>EINO MAGI</i>  |                                  |   |  | DATE SIGNED<br><i>4/13/58</i>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 22b. DATE THEREOF<br><i>4/16/1958</i>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Northwood Cemetery</i>  |  | 22d. LOCATION (City, town, or county) (State)<br><i>College Park, Md.</i>                         |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>W.W. Chambers Co - Riverdale, Md.</i>   |                                  |   |  | ADDRESS<br><i>Riverdale, Md.</i>   |  | 24a. REC'D BY REGISTRAR<br>DATE <i>APR 18 '58</i>   |  |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><i>W. H. Beach</i>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-1-10

|                  |  |                      |  |
|------------------|--|----------------------|--|
| NAME OF DECEASED |  | DATE OF DEATH        |  |
| PLACE OF DEATH   |  | CAUSE OF DEATH       |  |
| AGE              |  | SEX                  |  |
| OCCUPATION       |  | EDUCATION            |  |
| MARRIAGE         |  | RELIGION             |  |
| BIRTH            |  | DEATH                |  |
| FATHER           |  | MOTHER               |  |
| SISTER           |  | BROTHER              |  |
| CHILDREN         |  | GRANDCHILDREN        |  |
| PARENTS          |  | GRANDPARENTS         |  |
| Siblings         |  | Other relatives      |  |
| Social history   |  | Medical history      |  |
| Mental history   |  | Physical examination |  |
| Laboratory tests |  | X-ray                |  |
| Autopsy          |  | Other                |  |

BUREAU V. S.

APR 18 1958

RECEIVED

4964

CERTIFICATE OF DEATH

04955

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kentland Md</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>X</b> <b>Kentland Md.</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>3000 76th avenue..</b>  |                                  | d. STREET ADDRESS<br><b>3000 76th ave</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Henry</b> First <b>Thibodo</b> Middle <b>Thibodo</b> Last   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>11</b> Year <b>19 58-</b>   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 27, 1889</b>   |
| 9. AGE (In years last birthday) <b>68</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto Mechanic</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Massachusetts</b>                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |                                  |   |  |
| 13. FATHER'S NAME<br><b>John Thibodo</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Melvina Menard</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Mrs Henry Thibodo</b>   |                                  | Address<br><b>Kentland, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>181X</b> <b>Kremia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of bladder</b><br>DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)             |
| 20f. (City or town)   |                                  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>4/10/1958</b> to <b>4/11/1958</b> , that I last saw the deceased alive on <b>4/10/1958</b> , and that death occurred at <b>11:05 PM</b> , from the causes and on the date stated above.  |                                  |   |  |
| ADDRESS (Street, city or town, state) <b>2409 Varnum St. Landover Md.</b> DATE SIGNED <b>4/15/58</b>  |                                  |   |  |
| ACTUAL SIGNATURE <b>F. E. Musser</b> M.D.   |                                  |   |  |
| PHYSICIAN'S NAME (Type) <b>F. E. Musser MD</b>  |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>April 16, 1958 Burial</b>   | 22b. DATE THEREOF                | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St Bridget Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>North Hadley Massachusetts</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons Hyattsville Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 14 '58</b>   |  |
|   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>W. Beach</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

|                                    |  |                                  |  |   |  |
|------------------------------------|--|----------------------------------|--|---|--|
| NAME OF DECEASED<br>JAMES J. JONES |  | SEX<br>Male                      |  | AGE<br>30   |  |
| PLACE OF BIRTH<br>Baltimore, Md.   |  | DATE OF BIRTH<br>July 22, 1903   |  | PLACE OF DEATH<br>Baltimore, Md.                          |  |
| OCCUPATION<br>Salesman             |  | CAUSE OF DEATH<br>Heart Disease  |  | MANNER OF DEATH<br>Natural                                |  |
| DATE OF DEATH<br>July 22, 1933     |  | TIME OF DEATH<br>10:00 AM        |  | PLACE OF INTERMENT<br>St. Mary's Cemetery, Baltimore, Md. |  |
| SIGNATURE OF DECEASED<br>(None)    |  | SIGNATURE OF WITNESSES<br>(None) |  | SIGNATURE OF DECEASED'S NEAREST RELATIVE<br>(None)        |  |
| SIGNATURE OF PHYSICIAN<br>(None)   |  | SIGNATURE OF CORONER<br>(None)   |  | SIGNATURE OF REGISTRAR<br>(None)                          |  |

BUREAU V. 2

APR 14 1933

RECEIVED

4929

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>14 College Park</b>  |  |
| c. LENGTH OF STAY IN b<br><b>2 days</b>  |                                    | d. STREET ADDRESS<br><b>1 9907 - 51st Ave.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General</b>   |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Annie</b> Middle <b>L.</b> Last <b>Toombs</b>  |                                    | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>6</b> Year <b>1958</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>13 Dec 1873</b> |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.  |                                    | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Hartmoreland Co. Va</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>William F. Hart</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Bernice F. Smoot</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>-</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>-</b>   |  |
| 17. INFORMANT<br><b>Mrs. Ruby Leyboldt</b>   |                                    | Address <b>9907 - 51st Ave College Park, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Encephalomalacia due to cerebral ischemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized cerebral ischemia</b><br>DUE TO (c) <b>-</b> |                                    | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Carcinoma of stomach</b>   |                                    |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>4 Apr 58</b> to <b>6 Apr 58</b> , that I last saw the deceased alive on <b>4-5-58</b> 19, and that death occurred at <b>2:00a M.</b> from the causes and on the date stated above.  |                                    |   |  |
| ACTUAL SIGNATURE<br><b>Collet L Etienne</b> M.D.   |                                    | ADDRESS (Street, city or town, state) <b>4713 Tappan Rd College Park, Md</b> DATE SIGNED <b>4/6/58</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Wolcott L. Etienne, M. D.</b>   |                                    |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF<br><b>4/9/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>George Washington</b>  |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>4500 Riggs Road Hyattsville, Md.</b>   |                                    |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Halley Funeral Home</b>   |                                    | 24a. REC'D BY REGISTRAR<br><b>APR 9 '58</b>   |  |
| ADDRESS<br><b>Md.</b>  |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Albrecht</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## WYOMING STATE DEPARTMENT OF HEALTH—SALT LAKE CITY

**BUREAU V. S.**

APR 9 1958

RECEIVED

04957

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>University Park, Md<br>c. LENGTH OF STAY IN 1b<br>18 years<br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>4202 Colesville Road,.  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland<br>b. COUNTY Prince George's<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>X University Park, Md.<br>d. STREET ADDRESS<br>4202 Colesville, Road,.<br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Bessie Ullrich<br>4. DATE OF DEATH<br>Month Day Year<br>April 16, 19 58.  |  | 5. SEX female<br>6. COLOR OR RACE white<br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH<br>Jan 15, 1878<br>9. AGE (In years last birthday)<br>80 yrs.<br>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife<br>11. BIRTHPLACE (State or foreign country)<br>Maryland<br>12. CITIZEN OF WHAT COUNTRY?<br>U S A |  |
| 13. FATHER'S NAME<br>Samuel Watts<br>14. MOTHER'S MAIDEN NAME<br>Julia Anderson   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>no<br>16. SOCIAL SECURITY NO.<br>17. INFORMANT<br>Otto H Ullrich<br>Address<br>University Park, Md.  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 332x<br>DUE TO (b) Cerebral Thrombosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Arteriosclerosis, cerebral<br>DUE TO (c) Arteriosclerosis, general<br>INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>Yes   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19<br>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  | 21. I certify that I attended the deceased from MAY 1950, to APRIL 16, 1958, that I last saw the deceased alive on APRIL 15, 1958, and that death occurred at 5:30 A.M. from the causes and on the date stated above.<br>John F. Brennan Jr. M.D. 3425 12th St. N.E. April 16, 1958<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>John F. Brennan Jr. WASHINGTON 17, D.C.   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial<br>22b. DATE THEREOF<br>4/19/58<br>22c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln Cemetery<br>22d. LOCATION (City, town, or county) (State)<br>Colmar Manor, Maryland.  |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br>F. Gasch's Sons<br>ADDRESS<br>Hyattsville Md.<br>24a. REC'D BY REGISTRAR<br>DATE<br>24b. REGISTRAR'S SIGNATURE  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1953

|   |  |   |  |
|---|--|---|--|
| <p>1. NAME OF DECEASED<br/>                 [Faint text]</p>        |  | <p>2. SEX<br/>                 [Faint text]</p>                     |  |
| <p>3. AGE<br/>                 [Faint text]</p>                     |  | <p>4. DATE OF BIRTH<br/>                 [Faint text]</p>           |  |
| <p>5. PLACE OF BIRTH<br/>                 [Faint text]</p>          |  | <p>6. OCCUPATION<br/>                 [Faint text]</p>              |  |
| <p>7. MARITAL STATUS<br/>                 [Faint text]</p>          |  | <p>8. CAUSE OF DEATH<br/>                 [Faint text]</p>          |  |
| <p>9. MEDICAL HISTORY<br/>                 [Faint text]</p>         |  | <p>10. SIGNATURE OF PHYSICIAN<br/>                 [Faint text]</p> |  |
| <p>11. SIGNATURE OF REGISTRAR<br/>                 [Faint text]</p> |  | <p>12. SIGNATURE OF WITNESSES<br/>                 [Faint text]</p> |  |

BUREAU V. S.

APR 21 1953

RECEIVED

Reg. Dist. No. 04958

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Prince Georges</b> <span style="float: right;"><b>4966</b></span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b><br>c. LENGTH OF STAY IN 1b <b>unknown</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Odell Road, 1 mile East of Ellington</b>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Unknown</b> b. COUNTY <b>Unknown</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Unknown</b><br>d. STREET ADDRESS <b>Unknown</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>  |  | <b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>3</b> Year <b>19 58</b>  |  |
| <b>5. SEX</b> <b>Female</b><br><b>6. COLOR OR RACE</b> <b>white</b><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b> <b>Unknown</b><br><b>9. AGE</b> (In years last birthday) <b>Unknown</b> yrs.<br><b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b><br><b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b><br><b>11. BIRTHPLACE</b> (State or foreign country) <b>Unknown</b><br><b>12. CITIZEN OF WHAT COUNTRY?</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Unknown</b>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>None</b><br>(If yes, give war or dates of service)   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>17. INFORMANT</b> Address   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br>DUE TO (b) <b>Unknown cause</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |  | <b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |  |  |
| <b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> M.D.<br><b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>  |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>April 3, 1958</b>   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>   |  | <b>22b. DATE THEREOF</b> <b>4/10/58</b><br><b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Evergreen Cemetery</b><br><b>22d. LOCATION (City, town, or county)</b> (State) <b>Bladensburg, Md.</b>   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F. Gasch's Sons</b> <b>Hyattsville, Md.</b>   |  | <b>24a. REC'D BY REGISTRAR</b> <b>DATE APR 15 '58</b><br><b>24b. REGISTRAR'S SIGNATURE</b> <i>W. Gasch</i>   |  |

STATE OF  
MASSACHUSETTS

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                       |                              |
|-----------------------|------------------------------|
| NAME                  | John J. Sullivan             |
| AGE                   | 45                           |
| SEX                   | Male                         |
| RACE                  | White                        |
| DATE OF BIRTH         | 1913                         |
| PLACE OF BIRTH        | St. Louis, Mo.               |
| RESIDENCE             | 100 North St., Boston, Mass. |
| DATE OF DEATH         | April 15, 1958               |
| TIME OF DEATH         | 10:30 A.M.                   |
| PLACE OF DEATH        | Home                         |
| CAUSE OF DEATH        | Myocardial Infarction        |
| MANNER OF DEATH       | Natural                      |
| DEATH CERTIFICATE NO. | 100-15-1958                  |

RECEIVED  
APR 15 1958  
BUREAU V. S.

## 4887 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Washington, D.C.</u> b. COUNTY <u>D.C.</u>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47x-3</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>  |                                  | d. STREET ADDRESS <u>3630 Van Ness St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>A</u> Last <u>VINALL</u>  |                                  | 4. DATE OF DEATH<br>Month <u>APRIL</u> Day <u>16</u> Year <u>1958</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 23 1885</u> yrs. <u>73</u>                    |
| 9. AGE (In years last birthday) <u>73</u>  |                                  | 10. IF UNDER 1 YEAR: Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical Work</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Agriculture</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Edward Austin</u>   |                                  | 14. MOTHER'S MAIDEN NAME <u>Mary Mc Golrick</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |   |
| 17. INFORMANT <u>Sister Joan Therese</u> Address <u>Hyattsville, Md. 4922 LaSalle Rd.</u>  |                                  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart Failure</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u><br>DUE TO (c) <u>Hypertensive Arteriosclerotic Heart Disease</u> |                                  |  |   |
| INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u>  |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>April 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 13</u> , 19 <u>58</u> , and that death occurred at <u>1:15</u> P. M., from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE <u>James J. Foster</u>  |                                  | ADDRESS (Street, city or town, state) <u>1746 K St. N.W. Wash. D.C.</u> DATE SIGNED <u>4/16/58</u>   |   |
| PHYSICIAN'S NAME (Type) <u>James J. Foster</u>   |                                  | <u>WASH. D.C.</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>4-18-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>  | 22d. LOCATION (City, town, or county) (State) <u>Southland Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-14th St. N.W., Wash. D.C.</u>   |                                  | 24a. REC'D BY REGISTRAR <u>APR 17 '58</u> DATE <u>APR 17 '58</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APD 17 21 838

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04960

Reg. Dist. No.

4930

FOR STATE  
HEALTH DEPT.

|  |                                  |   |                                    |   |   |  |                                  |
|--|----------------------------------|---|------------------------------------|---|---|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> |   |  |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cedar Heights</b>                                    |   |  |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |                                  |   |                                    | d. STREET ADDRESS<br><b>6305 Sheriff Road</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alice</b> Middle <b>Wade</b> Last  |                                  |   |                                    | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>1</b> Year <b>1958</b>  |   |  |                                  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-21-11</b> | 9. AGE (In years last birthday)<br><b>46</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Seamstress</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  |
| 13. FATHER'S NAME<br><b>Isom Field</b>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Cora Lee Pinkard</b>   |   |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><b>William A. Wade; same address as # 2.</b>   |   |  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gunshot wound of head</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |                                    |   |   |  | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Self inflicted gunshot wound of head</b>                 |                                    |   |   |  |                                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>4-1-</b> 19 <b>58</b> p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>home</b>   |   | 20f. (City or town) (County) (State)<br><b>Cedar Heights, Pr. Geo., Md.</b>            |                                  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>             |                                  |   |                                    |   |   |  |                                  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>  |                                  |   |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  |                                  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |                                  |   |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 1, 1958</b>  |   |  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4-4-58</b>  |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Washington DC</b>                  |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Henry S. Washington Sr</b>  |                                  |   |                                    | ADDRESS<br><b>467 N. of NW</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 7 '58</b>                                       |                                  |
|  |                                  |   |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>W. Beach</b>   |   |  |                                  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
BUREAU V. S.

BUREAU V. S.

APR 7 1953

RECEIVED

4931

## CERTIFICATE OF DEATH

04961

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  |   |  | c. LENGTH OF STAY IN TB<br><b>7 Days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Prince George General</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cora</b> Middle <b>B.</b> Last <b>Walker</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>1</b> Year <b>1958</b>  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9-24-95</b>                                       |  |
| 9. AGE (In years last birthday)<br><b>62</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>J. Harry Barnes</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Sullivan</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  |   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)  |  | 17. INFORMANT<br><b>George Walker</b><br>Address <b>Hyattsville, Md.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b><br><b>203X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |   |  |   |  |  | INTERVAL BETWEEN ONSET OF DEATH<br><b>7 months</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town)  |  |   |  | (County)  |  | (State)  |  |
| 21. I certify that I attended the deceased from <b>9-7-57</b> , 19 <b>57</b> , to <b>4-1-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-1</b> , 19 <b>58</b> , and that death occurred at <b>3:27 P</b> M, from the causes and on the date stated above.   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John P. Clum</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>4110 43rd Ave Hyattsville Md</b>   |  |  |  |
| DATE SIGNED <b>4-1-58</b>  |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. John P Clum</b>   |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Apr. 4, 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Easton, Md.</b>      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Maurice E. Newnam &amp; Son</b>   |  |   |  | ADDRESS<br><b>Easton, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>APR 8 '58</b>                              |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>W. J. Search</b>  |  |   |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

APR 8 1958

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04962

Reg. Dist. No.

4967

FOR STATE  
HEALTH DEPT.

|   |                               |  |                                      |   |  |  |  |
|---|-------------------------------|--|--------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND   |                               |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>   |                               |  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>   |  |  |  |
| c. LENGTH OF STAY IN 1b <u>4 weeks</u>  |                               |  |                                      | d. STREET ADDRESS <u>12310-Norcross St</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2310-Norcross St</u>  |                               |  |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Marguerite</u> Middle <u>Louise</u> Last <u>Weber</u>  |                               |  |                                      | 4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1958</u>  |  |  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 25, 1957</u> |   | 9. AGE (in years last birthday) yrs. <u>3</u> Months <u>29</u> | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>29</u> Hours <u></u> Min. <u></u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>   |                               |  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>U. S. C.</u>                                      |  |
| 13. FATHER'S NAME <u>Charles Joseph Weber</u>   |                               |  |                                      | 14. MOTHER'S MAIDEN NAME <u>Margaret Mary Campuzano</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |                               |  |                                      | 16. SOCIAL SECURITY NO. <u></u>   |  | 17. INFORMANT <u>Charles J. Weber same as #2</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO <u>491X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Aspiration of food</u><br>DUE TO <u>Bronchopneumonia</u><br>(c) <u></u>   |                               |  |                                      |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |                               |  |                                      |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               |  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |                                      |   |  |  |  |
| ACTUAL SIGNATURE <u>James I. Boyer</u>  |                               |  |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) <u>JAMES I. BOYER</u>  |                               |  |                                      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
|   |                               |  |                                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL, or other disposition <u>Transportation</u>   |                               | 22b. DATE THEREOF <u>4/23/58</u>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY <u>Philadelphia</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Pennsylvania</u>                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>   |                               |  |                                      | ADDRESS <u>Hyattsville Md.</u>  |  | 24a. REC'D BY REGISTRAR <u>Al. Leach</u>   |  |
|   |                               |  |                                      | 24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>   |  | DATE <u>APR 25 '58</u>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051343XV3

FOR STATE  
IN ALL DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 25 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04963**

**4932**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                    |   |   |
|--|------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b><br>MARYLAND  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Pr. Geo.</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |                                    | d. STREET ADDRESS<br><b>4718 41st Place</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Harrison Eugene White</b>   |                                    | 4. DATE OF DEATH<br>Month Day Year<br><b>April 3, 19 58</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-11-95</b>                                    |
| 9. AGE (In years last birthday)<br><b>63</b> yrs.  |                                    | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Dist. of Columbia</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Henry White</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Clara ?</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>W.W. 1</b>  |   |
| 17. INFORMANT<br><b>Louise Phillips; Same address as # 2.</b>  |                                    | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br><b>442x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b><br>(a), stating the underlying cause lost. DUE TO (c)   |                                    |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                    |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                    |   |   |
| ACTUAL SIGNATURE<br><b>John T. Maloney</b>   |                                    | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>John T. Maloney, M.D.</b>   |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                    | DATE SIGNED<br><b>April 3, 1958</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>4-8-58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Va.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John T. R. Linder</b>   |                                    | ADDRESS   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>APR 7 '58</b>   |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. Beach</b>  |   |

STATEMENT OF DEATH - BIRMINGHAM 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1932

John T. Wilson

Spencer

Spencer Hospital

Spencer

Colored

2-11-32

Spencer

Spencer

Yes

1932

Spencer

Spencer

BUREAU V. S.

APR 7 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 04964

|   |                        |  |                            |
|---|------------------------|--|----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Maryland b. COUNTY Prince Georges  |                            |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.  |                        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier   |                            |
| c. LENGTH OF STAY IN TB 3 Months  |                        |  |                            |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Home   |                        | d. STREET ADDRESS 14304 Raywood Drive  |                            |
| 3. NAME OF DECEASED (Type or print) Loretta C. Wolfe  |                        | 4. DATE OF DEATH 4-2-1958  |                            |
| 5. SEX Female   | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH 9/21/1890 |
| 9. AGE (In years last birthday) 64 yrs.   |                        | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Dep. of Gov.  |                        | 10b. KIND OF BUSINESS OR INDUSTRY Government, Providence, R.I.   |                            |
| 11. BIRTHPLACE (State or foreign country) U.S.  |                        | 12. CITIZEN OF WHAT COUNTRY? U.S.  |                            |
| 13. FATHER'S NAME Thomas Hartford   |                        | 14. MOTHER'S MAIDEN NAME Mary Agers  |                            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                        | 16. SOCIAL SECURITY NO.  |                            |
| 17. INFORMANT Thomas H. Wolfe   |                        | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of breast with generalized metastasis<br>170X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) |                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                        | INTERVAL BETWEEN ONSET AND DEATH 2 yrs.  |                            |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        |  |                            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                            |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19   |                        | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>   |                            |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |                            |
| 21. I certify that I attended the deceased from Sept. 1, 1956, to Apr. 2, 1958, that I last saw the deceased alive on Apr. 1, 1958, and that death occurred at 11:30 P.M. from the causes and on the date stated above. |                        |  |                            |
| ACTUAL SIGNATURE Thomas F. Collins M.D.   |                        | ADDRESS (Street, city or town, state) 322 H. M. N. E. D. C. DATE SIGNED Apr. 2, 1958   |                            |
| PHYSICIAN'S NAME (Type) Thomas F. Collins   |                        |  |                            |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped   |                        | 22b. DATE THEREOF  |                            |
| 22c. NAME OF CEMETERY OR CREMATORY  |                        | 22d. LOCATION (City, town, or county) (State) Boston Mass.   |                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE Naaleys Funeral Home   |                        | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE   |                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| <p>1. NAME OF DECEASED<br/>                 [Faint handwritten name]</p>             |  | <p>2. SEX<br/>                 [Faint handwritten sex]</p>                             |  |
| <p>3. AGE<br/>                 [Faint handwritten age]</p>                           |  | <p>4. DATE OF BIRTH<br/>                 [Faint handwritten date]</p>                  |  |
| <p>5. PLACE OF BIRTH<br/>                 [Faint handwritten place]</p>              |  | <p>6. OCCUPATION<br/>                 [Faint handwritten occupation]</p>               |  |
| <p>7. MARITAL STATUS<br/>                 [Faint handwritten status]</p>             |  | <p>8. CAUSE OF DEATH<br/>                 [Faint handwritten cause]</p>                |  |
| <p>9. MEDICAL HISTORY<br/>                 [Faint handwritten history]</p>           |  | <p>10. SIGNATURE OF PHYSICIAN<br/>                 [Faint handwritten signature]</p>   |  |
| <p>11. SIGNATURE OF REGISTRAR<br/>                 [Faint handwritten signature]</p> |  | <p>12. DATE OF DEATH<br/>                 [Faint handwritten date]</p>                 |  |
| <p>13. PLACE OF DEATH<br/>                 [Faint handwritten place]</p>             |  | <p>14. SIGNATURE OF WITNESS<br/>                 [Faint handwritten signature]</p>     |  |
| <p>15. SIGNATURE OF DECEASED<br/>                 [Faint handwritten signature]</p>  |  | <p>16. SIGNATURE OF NEXT OF KIN<br/>                 [Faint handwritten signature]</p> |  |

BUREAU V. S.

APR 7 1931

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4899 CERTIFICATE OF DEATH

Reg. Dist. No. 04965

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGE</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Washington, DC.</u> b. COUNTY                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hyattsville</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u> 47X-3 ✓  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>CARROLL MANOR 4922 LaSalle Road</u>  |   | d. STREET ADDRESS<br><u>324 Channing ST. N.E.</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>FRANK</u> Middle <u>I</u> Last <u>ZERKLE</u>  |   | 4. DATE OF DEATH<br>Month <u>APRIL</u> Day <u>13</u> Year <u>1958</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>February 21, 1881</u>                                   |
| 9. AGE (In years last birthday)<br><u>77</u> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Treasury Dept, Govt</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>OHIO</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>  |  |
| 13. FATHER'S NAME<br><u>RICHARD Zerkle</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Jane Snyder</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>   |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |  |
| 17. INFORMANT<br><u>Sister M. Jean Thorne</u>   |   | Address<br><u>4922 LaSalle Rd.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF PROSTATE C METASTASIS</u><br>DUE TO <u>TO BLADDER</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CONGESTIVE HEART FAILURE DUE MITRAL STENOSIS</u><br>(c) <u>2 years</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 days</u>                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>56</u> , to <u>April 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 13</u> , 19 <u>58</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE<br><u>Thomas F. Collins</u>  |   | ADDRESS (Street, city or town, state)<br><u>323 - H ST NE</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>THOMAS F. COLLINS</u>   |   | DATE SIGNED<br><u>192</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>  | 22b. DATE THEREOF<br><u>4/16/58</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Pr. Geo. Co., Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>The S.H. Hines Co., 2901 14th St. N.W.</u>   |   | 24a. REC'D BY REGISTRAR<br><u>DATE APR 15 '58</u>  | 24b. REGISTRAR'S SIGNATURE<br><u>Dee Smith</u>                                 |

CERTIFICATE OF DEATH

|  |  |                                     |  |                                       |  |
|--|--|-------------------------------------|--|---------------------------------------|--|
| 1. NAME OF DECEASED<br>JOHN J. ROSS      |  | 2. SEX<br>Male                      |  | 3. AGE<br>65                          |  |
| 4. DATE OF DEATH<br>April 15, 1958       |  | 5. TIME OF DEATH<br>10:30 AM        |  | 6. PLACE OF DEATH<br>Home             |  |
| 7. CAUSE OF DEATH<br>Coronary Thrombosis |  | 8. MANNER OF DEATH<br>Natural       |  | 9. PLACE OF BIRTH<br>Maryland         |  |
| 10. DATE OF BIRTH<br>March 1, 1893       |  | 11. SEX OF BIRTH<br>Male            |  | 12. AGE AT BIRTH<br>65                |  |
| 13. OCCUPATION<br>Retired                |  | 14. EDUCATION<br>High School        |  | 15. RELIGION<br>Roman Catholic        |  |
| 16. MARITAL STATUS<br>Married            |  | 17. NAME OF SPOUSE<br>Mary J. Ross  |  | 18. DATE OF MARRIAGE<br>June 15, 1915 |  |
| 19. PREVIOUS MARRIAGES<br>None           |  | 20. NAME OF PREVIOUS SPOUSE<br>None |  | 21. DATE OF PREVIOUS MARRIAGE<br>None |  |
| 22. NAME OF PHYSICIAN<br>Dr. J. H. Smith |  | 23. NAME OF HOSPITAL<br>None        |  | 24. NAME OF NURSE<br>None             |  |
| 25. NAME OF FUNERAL HOME<br>None         |  | 26. NAME OF BURIAL PLACE<br>None    |  | 27. NAME OF CEMETERY<br>None          |  |
| 28. NAME OF INTERMENT PLACE<br>None      |  | 29. NAME OF INTERMENT DATE<br>None  |  | 30. NAME OF INTERMENT TIME<br>None    |  |
| 31. NAME OF INTERMENT PLACE<br>None      |  | 32. NAME OF INTERMENT DATE<br>None  |  | 33. NAME OF INTERMENT TIME<br>None    |  |
| 34. NAME OF INTERMENT PLACE<br>None      |  | 35. NAME OF INTERMENT DATE<br>None  |  | 36. NAME OF INTERMENT TIME<br>None    |  |
| 37. NAME OF INTERMENT PLACE<br>None      |  | 38. NAME OF INTERMENT DATE<br>None  |  | 39. NAME OF INTERMENT TIME<br>None    |  |
| 40. NAME OF INTERMENT PLACE<br>None      |  | 41. NAME OF INTERMENT DATE<br>None  |  | 42. NAME OF INTERMENT TIME<br>None    |  |
| 43. NAME OF INTERMENT PLACE<br>None      |  | 44. NAME OF INTERMENT DATE<br>None  |  | 45. NAME OF INTERMENT TIME<br>None    |  |
| 46. NAME OF INTERMENT PLACE<br>None      |  | 47. NAME OF INTERMENT DATE<br>None  |  | 48. NAME OF INTERMENT TIME<br>None    |  |
| 49. NAME OF INTERMENT PLACE<br>None      |  | 50. NAME OF INTERMENT DATE<br>None  |  | 51. NAME OF INTERMENT TIME<br>None    |  |
| 52. NAME OF INTERMENT PLACE<br>None      |  | 53. NAME OF INTERMENT DATE<br>None  |  | 54. NAME OF INTERMENT TIME<br>None    |  |
| 55. NAME OF INTERMENT PLACE<br>None      |  | 56. NAME OF INTERMENT DATE<br>None  |  | 57. NAME OF INTERMENT TIME<br>None    |  |
| 58. NAME OF INTERMENT PLACE<br>None      |  | 59. NAME OF INTERMENT DATE<br>None  |  | 60. NAME OF INTERMENT TIME<br>None    |  |
| 61. NAME OF INTERMENT PLACE<br>None      |  | 62. NAME OF INTERMENT DATE<br>None  |  | 63. NAME OF INTERMENT TIME<br>None    |  |
| 64. NAME OF INTERMENT PLACE<br>None      |  | 65. NAME OF INTERMENT DATE<br>None  |  | 66. NAME OF INTERMENT TIME<br>None    |  |
| 67. NAME OF INTERMENT PLACE<br>None      |  | 68. NAME OF INTERMENT DATE<br>None  |  | 69. NAME OF INTERMENT TIME<br>None    |  |
| 70. NAME OF INTERMENT PLACE<br>None      |  | 71. NAME OF INTERMENT DATE<br>None  |  | 72. NAME OF INTERMENT TIME<br>None    |  |
| 73. NAME OF INTERMENT PLACE<br>None      |  | 74. NAME OF INTERMENT DATE<br>None  |  | 75. NAME OF INTERMENT TIME<br>None    |  |
| 76. NAME OF INTERMENT PLACE<br>None      |  | 77. NAME OF INTERMENT DATE<br>None  |  | 78. NAME OF INTERMENT TIME<br>None    |  |
| 79. NAME OF INTERMENT PLACE<br>None      |  | 80. NAME OF INTERMENT DATE<br>None  |  | 81. NAME OF INTERMENT TIME<br>None    |  |
| 82. NAME OF INTERMENT PLACE<br>None      |  | 83. NAME OF INTERMENT DATE<br>None  |  | 84. NAME OF INTERMENT TIME<br>None    |  |
| 85. NAME OF INTERMENT PLACE<br>None      |  | 86. NAME OF INTERMENT DATE<br>None  |  | 87. NAME OF INTERMENT TIME<br>None    |  |
| 88. NAME OF INTERMENT PLACE<br>None      |  | 89. NAME OF INTERMENT DATE<br>None  |  | 90. NAME OF INTERMENT TIME<br>None    |  |
| 91. NAME OF INTERMENT PLACE<br>None      |  | 92. NAME OF INTERMENT DATE<br>None  |  | 93. NAME OF INTERMENT TIME<br>None    |  |
| 94. NAME OF INTERMENT PLACE<br>None      |  | 95. NAME OF INTERMENT DATE<br>None  |  | 96. NAME OF INTERMENT TIME<br>None    |  |
| 97. NAME OF INTERMENT PLACE<br>None      |  | 98. NAME OF INTERMENT DATE<br>None  |  | 99. NAME OF INTERMENT TIME<br>None    |  |
| 100. NAME OF INTERMENT PLACE<br>None     |  | 101. NAME OF INTERMENT DATE<br>None |  | 102. NAME OF INTERMENT TIME<br>None   |  |

BUREAU V. S.

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